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THE UNIVERSITY OF ALBERTA

DEVELOPMENT OF THE VOLUNTEER EMPATHY TEST

BY

JAMES RAYMOND CANNIFF

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF DOCTOR OF PHILOSOPHY IN COUNSELING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1990

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Development of the Volunteer Empathy Test" submitted by James Raymond Canniff in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

(Supervisor)

Date: October 8 1990

Dedication

For Edie, Andrew, and Caitlin

"The Unsung Volunteers"

Abstract

This research established initial reliability and validity for a newly constructed multiple choice test of empathy. Original test items were composed from cancer patient and palliative care patient questions and research responses, based on Carkhuff's Empathic Understanding in Interpersonal Process Scale (1969). From a beginning pool of 75 potential test items, 30 were chosen where the item to total correlation coefficient was greater than +.4 after a sample of 381 university students was administered the questionnaire. Five experts in the area of palliative care and empathy then completed the revised thirty item questionnaire and a further six multiple choice questions were eliminated. The remaining 24 items formed the Volunteer Empathy Test (VET). The VET along with another known empathy measure (Interpersonal Reactivity Index) was then administered to contrasting groups thought to be high and low empathic. A statistical analysis of results was completed, including test-retest reliability.

The literature reviewed provided support for the use of a situation-specific multiple choice measure to examine communicated empathy. Generally most available empathy measures did not view empathy as a set of specific construct which could be measured, with the exception of the Interpersonal Reactivity Index (IRI).

Results of this study provided statistical support for the restricted use of the Volunteer Empathy Test in concert with other screening devices concerned with measuring communicated empathy in palliative care settings.

Implications and suggestions for further research emphasized the need for comparison of the VET with other measures, across various settings and groups and in general, an evaluation of its predictive value.

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CHAPTER I

Introduction

General Overview

The move to increased hospice and other palliative care programs has contributed to a change in the role of volunteers. Volunteer personnel have become involved in direct patient care and are encountering more situations that are sensitive and highly emotional in nature. Knowing how a helper will respond to these sensitive situations is important as it ultimately affects the feelings of the patient. Empathy has been identified as an important component of the effective response of successful volunteers (Clay, 1984; Tyner, 1985).

A study of the literature reveals the possibility of measuring communicated empathy, and therefore, of developing an instrument that could be used for screening potential volunteers to determine their level of empathy. If such a measure is cost effective, makes some predictions about individuals likely to benefit from training, and has some potential as a training device, it will be beneficial to administrators within health care organizations that strive to provide optimal interactions between patients and caregivers, and more specifically, between patients in palliative care settings and volunteers.

Purpose of the Study

The intent of this study is to develop and establish initial reliability and validity for the Volunteer Empathy Test (VET). This measure will consist of multiple-choice questions. Stems will be based on palliative care patient reported statements and alternatives paralleling levels of empathy corresponding to Carkhuff's Empathic Understanding in Interpersonal Process Scale (1969). The underlying assumptions of the test are that empathy is an essential skill for volunteers in palliative care or other related health care settings, that levels of communicated empathy can be measured, and that the availability of a cost effective measure to identify individuals as being either high in or lacking in communicated empathy would facilitate more effective screening of volunteer personnel. A final assumption is that a measure such as the Interpersonal Reactivity Index which proports to measure differing constructs of empathy does not replace the need for a specific measure of communicated empathy in a palliative care setting.

The Nature of the Problem

Relationships Between Volunteers and Palliative Care Services

In examining the role of volunteers, Relf and Couldrick (1988) note that it has only been during the last fifteen

years that professionals and volunteers have begun to work together to provide services that would not be possible if this partnership did not exist. In fact, the role of volunteers in palliative and related health care settings has emerged as being important in providing patient centered nurturing and caring (Jolley, 1988; Relf & Couldrick, 1988; van Bommel, 1987; Zimmerman, 1981).

This is especially true of the hospice movement with hospices being defined by Wilkinson and Wilkinson (1986) as a "multidisciplinary medically-directed program which provides supportive and palliative care to terminally ill patients and their families" (p. 263). Of the characteristics desired for volunteer personnel who comprise the hospice team, Zimmerman (1981) notes that they need to be competent and that they are the source of a critical cost and quality issue. He describes hospice care as being labour intensive with patients requiring a high level of personal attention and notes that it is the support provided by volunteers that allows for possible program staffing expenses to be defrayed. The volunteer becomes an individual who is readily available to spend time with the patient and family and to provide special services as needed.

In looking at the services provided by volunteers in palliative care, it is also important to examine the needs and feelings of the patients and their families. Van Bommel

(1987) notes that individuals do not fundamentally change because of their illness and that how they approach situations and communicate to others before and after they are ill will, for the most part, remain constant. He continues by stating, "in fact, finding out about terminal illness changes someone less than it does the people around them" (p. 127). What does change is the need for the patient to receive continuity of care (Jolley, 1988). Jolley sees the volunteer as contributing to providing an underlying security to help the patient cope with the different professionals, treatments, stigma of having the disease, unrelieved pain and feelings of isolation.

Selection of Volunteers

It is because volunteers frequently are placed in a potentially sensitive role of working closely with and providing emotional support to patients and their families (Wilkinson & Wilkinson, 1986) that selection and training of volunteers has to be done with care. This is emphasized by Knowles (1979) who in his study finds that as few as 9% of the volunteers for a telephone crisis line are engaging in appropriate reflective behaviours, while as many as 70% are engaging in inappropriate advisement behaviours which the author notes would prevent the caller from developing feelings of being heard and accepted. This is further supported by McCarthy and Berman (1971), as well as by Gray, Nida, and Coonfield (1976) who state that "a listener's

responses leave the caller with a sense of hopefulness, as opposed to the helplessness experienced when crisis coping skills are inadequate" (p. 4). Thus, the potentially harmful effects of volunteers acting on value systems or beliefs that are inconsistent with those of the helping agency and the need for determining an individual's motives for volunteering are highlighted.

Motives for Volunteering

When determining how volunteers' motivations differ from those of salaried and professional workers, Rossing (1988) notes that in the past volunteers have selected intrinsically satisfying activities. However, the trend has changed between workers and volunteers and they have become much more alike. Rossing states that workers now tend to look for opportunities that allow for creativity, while volunteers have become aware that experience could develop job related skills. When defining volunteering, Rossing (1988) refers to it as a "freely chosen, unpaid individual activity carried out for a variety of motives" (p. 38). In discussing hospice programs and palliative care, Markey (1980) and Howarth (1984) examine the motives (such as desire for personal growth, unresolved past losses, desire to relieve guilt, or need to promote a religious view) of the volunteers and note that individuals could be accepted or rejected on this basis. Motivation in terms of a desire to ascertain another's point of view is discussed by both

Taft (1955) and Gray et al.(1976). A motivated individual demonstrates a high level of interest which, in turn, allows the person seeking help to feel understood.

How Volunteers Approach Tasks

In addition to motives, Rossing states that volunteers and salaried workers often differ in how they approach their tasks. He notes that "the volunteer typically acts on the basis of his or her reservoir of experience and values, without specialized training" (Rossing, 1988, p. 39), and while this is appropriate for routine tasks, this is not appropriate for new situations. Epstein (1975) and Buchanan (1984) discuss behaviors such as avoidance and unbridled enthusiasm that interfere with empathic responses and that result from the helpers' inability to cope with their own responses or their lack of insight into their own fears and defences employed against these fears. Genthner (1974) suggests that "low-functioning helpers are controlled by their helpees on relevant helping process variables" (p. 412). Thus, facilitative helping in his study shows an increase with the client's high self-exploration, decrease with low client self-exploration, and an increase again when the helper is confronted by a client claiming that she is not being helped. However, the author notes that the levels are still not at Level 3 of Carkhuff's Empathic Understanding in Interpersonal Process Scale (1969) with this level needed for an individual to be at least minimally

helpful. Like Knowles (1979), Genthner notes inappropriate responses to helpees' expressed feelings and concludes that a minimal competence in skills necessary for the tasks that are required should be demonstrated before an individual becomes a helper.

Volunteer Qualities

Examining the qualities that may be common among volunteers, especially those who are rated as "successful" in their work is important to the task of screening. Wilkinson and Wilkinson (1986) state the following:

> Those who come for volunteer training perceive themselves as low in anxiety and feel they are generally in control of their lives, are understanding and empathic (though retaining some objectivity) and are willing to give of their time and themselves to help individuals with a very serious problem--facing terminal illness and its ramifications. (p. 271)

Howarth's (1976) findings also note that volunteers are less anxious and tend to exhibit qualities of persistence, trust, and greater conscientiousness (as compared with general student populations). This is supported by Taft (1955) who notes that individuals who demonstrate good emotional adjustment and social skills tend to be good judges, while those who are poorly adjusted are not only poor judges but are more likely to let personal biases affect their

judgments.

Hogan's (1969) study correlates with the qualities that Wilkinson and Wilkinson (1986) see as being common among volunteers. He makes comparisons between the high and low scorers on his empathy measure. He notes that the individual who scores higher on the empathy scale "seems likeable and friendly, possessing considerable charm, poise, and tact" (Hogan, 1969, p. 315). He also describes this high scorer as being at ease in interpersonal situations and includes the words "warm and friendly" in his description. On the other hand, Hogan (1969) states that "the low scorer on the empathy scale appears somewhat aloof, disaffected, and disposed to alienate those around him" (p. 315). Thus, there appears to be a clear association between the qualities desired in a volunteer in the palliative or health care setting and the level of empathy that an individual possesses.

Another dimension that volunteers may bring to the task is labelled as "trait empathy" by Steibe, Boulet, and Lee (1979). This is defined by the authors as a natural empathic disposition and is judged to be important because it can affect training outcomes for volunteers.

The need for this empathy is clarified by Tyner (1985) as she sees it as a way to "reach the essence of care for the dying and the family" (p. 393). Empathy is, for her, the link between what the patient is feeling internally and

what the caregiver is able to express externally in the form of behaviors and attitudes toward the patient.

Defining Empathy

While it is accepted that empathy is the quality that individuals must have in order to participate in effective and positive helpful relationships (Gray et al., 1976; Wilkinson & Wilkinson, 1986), empathy has been difficult to define and many problems have existed with the tests that have been developed to measure this quality. Whether empathy is a state or a process, is made up of a number of abilities, or is a combination of cognitive and affective components has not yet been clearly determined. There has also been a question as to whether empathy is in actual fact the sum total of these components or the "gestalt" of all that is believed to be empathy.

Need for an Instrument for Screening Empathy in Volunteers

After surveying 253 crisis centers, McCord and Packwood (1973) found that "three-fourths of the crisis centers use the training procedure itself as a screening device" (p. 725). The next most favored method (and often used in conjunction with other methods), is one-to-one interviews by the director or a staff member. As few as 30% of centers use a formal screening procedure which follows a defined sequential set of procedures, and only about 13% use any psychological testing. Of the tests that are favored by those who do use psychological measures, the Minnesota

Multiphasic Personality Inventory (MMPI) and the California Psychological Inventory (CPI) are reported. Only 26% of the centers use psychologists or psychiatrists for screening prospective helpers. In determining the characteristics necessary for successful application, the centers tend to rely on subjective evaluations and the authors note that empathy is the quality most often listed as being desirable.

As part of their definition of a committed volunteer, Wilkinson and Wilkinson (1986) also include the notion of retaining some objectivity while still remaining understanding and empathic. For this reason, they state that "individuals who feel that they are able to maintain control in situations of stressful emotional content are also those who report themselves as most able to cope with situations involving terminal illness and death" (Wilkinson & Wilkinson, 1986, p. 273). As noted earlier, palliative care and hospice programs need to screen volunteers on the basis of motivations and to carefully look at the individual's experiences with death, especially if the experience has been a recent one.

Rogers (1975) expresses concern for personality disturbances in counselors as he notes that it will contribute to lower empathic understanding. In their study, Coke, Batson, and McDavis (1978) found that subjects do make a distinction between emotional states of empathic concern and personal distress, though they note that both emotions

are experienced as unpleasant. The researchers also state that the subjects who experience greater empathic emotion are significantly more likely to help.

Because of Rossing's (1988) finding that a volunteer typically acts on his or her own reservoir of experience and values, knowing what these values and experiences are seems essential. For volunteers of the past whose roles included tasks that did not involve personal interactions with individuals such as those who were sick and dying, it was perhaps not as necessary to know how each individual would react in problem situations. Taft (1955) discusses the role of emotional adjustment in individuals making accurate judgments and notes that poorly adjusted individuals tend to make inaccurate assessments and to allow their own personal biases to affect their perceptions. The ability to act in a need situation is clarified by Coke et al. (1975) who write that observing a person in distress produces arousal which might be cognitively interpreted by the observer as an aversive emotion. This, in turn, will motivate the observer to reduce the arousal either by helping or by escaping the distress. Gladstein (1983) summarizes consequences of this by stating, "we need to develop methods for determining when emotional reactions occur and for discovering when their levels are not facilitative" (p. 477).

Criteria for a Test Instrument

The concept of levels of responses to need situations is discussed by Carkhuff (1969). By either observing an individual's behavior or by examining his or her responses in a helping situation, one could, according to Carkhuff, measure the level of interpersonal functioning. He notes the difficulties in observing levels of functioning and concludes that "it is the interpersonal expression of experiences in a given problem area that leads to the helping process" (Carkhuff, 1969, p. 21). Of importance to measures of empathy is his notion of obtaining an over-all measure of functioning (how one individual compares with others) as well as an indication of differing response levels to various problems within an individual.

The development of an instrument which will allow subjects to answer questions based on actual patient statements will be a situational measure which will have more probability for success than a predictive measure will (Deutsch & Madle, 1975). These same authors define predictive and situational measures in the following way:

> Predictive measures have been concerned with a person's accuracy in predicting the self-ratings or preferences of another individual (Dymond et al., 1953) or group (Kerr and Speroff, 1954). Situational measures, on the other hand, have assessed "cognitive empathy" by having the person identify another's affect alone (e.g. Borke,

> 1971) and with a situation (e.g. Deutsch, 1974a, 1975) or have measured "affective empathy" by asking the subject what feelings he shares with another (e.g. Feshbach and Roe, 1969), or by providing appropriate "helping which is assumed to be the result of shared feelings (e.g. Danish and Kagan, 1971)". (p. 272)

In addition, by examining prospective volunteers' individual responses to the items, administrators are more likely to gain an understanding of how these volunteers will react in varying situations related to health care. An instrument that can be given to a large group of individuals at one sitting, but that could allow program directors to have a sense of the individual by the pattern of responses (which may imply a need for further screening) or by the items that present difficulties (which may indicate areas needing further training or situations which may generally be inappropriate to expect a volunteer to cope with), will be of particular value both for cost effectiveness and for speed of selection.

For the individual seeking entrance into a palliative care volunteer program or related health care setting, a measure that explores actual patient statements has some distinct advantages. Simply by completing the test, the subjects will become more familiar with the type of setting and the problems that they might encounter within this setting. If this experience proves to be disturbing for

individuals, or if it raises questions that need clarifying about program objectives, they will then be able to investigate their commitment for continuing in their chosen field.

An instrument which uses a multiple-choice format can be both cost saving and objective. This type of measure will allow for rapid, accurate, and unbiased scoring and thus will enable administrators to place prospective volunteers more expediently. The use of multiple-choice items also will have a greater possibility of content validity (Chenevey, 1988). A volunteer's empathic responses to actual palliative care situations also has the advantage of reflecting one of the objectives of most palliative care and hospice programs.

Implications for training can be determined by a measure which requires a volunteer to respond to actual patient statements. Simply by answering the items, individuals are being exposed to situations that might arise in a palliative care setting. Some prospective volunteers may chose to withdraw before training, after having the opportunity to read about situations they may encounter. For other prospective volunteers, by making choices regarding their responses to actual situations, they are already gaining experience in making appropriate helping choices. Rogers (1957) discusses experience as enhancing empathy. A multiple-choice format also has the further

additional benefit of being transferable to computer format in order to allow the use of an answer-until-correct scoring procedure (defined by Wilcox and Wilcox, 1988, as allowing the individual to receive feedback immediately after an item is answered and this process continues until the desired response is obtained). The measure can then be used as a training device. In addition, both as a computer test or a paper-and-pencil test, the instrument has possibilities for allowing individuals to complete it at their own leisure and to use the results in making decisions about career choices.

Palliative and related health care programs need volunteers who are able to respond empathically to their patients. A screening measure to assist in determining this will be most effective if it is a situational measure that allows individuals to respond to problem statements, that gives a total score and a pattern of responses score, and that uses a multiple-choice format so that administration and scoring of the measure can be completed in an expedient manner. A device that uses unambiguous scoring so that each response corresponds to a particular score will allow for greater reliability, and the patterns of responses and exposure to the situations on the measure will allow individuals, as well as the administrators, to make more knowledgeable decisions regarding volunteers and volunteering in the palliative and related health care fields.

This study will undertake the task of developing such an instrument. Statistical analysis to explore initial reliability and validity will be completed and conclusions drawn. Whether a multiple choice instrument measuring communicated empathy based on palliative care situations can be developed, whether this instrument can be of use in the screening of potential volunteers, and whether it can be used for other clinical applications such as in the actual training of selected volunteers will be considered by this research. The need for such an instrument has been demonstrated in both the literature and clinical circumstances.

CHAPTER II

Review of the Literature

The term "empathy" has been the cause of much debate and disagreement in the literature. While there seems to be a general consensus that this quality is essential to helping, whether in the health care field or other related areas, defining this quality and providing a reliable and valid instrument to measure it has been the focus of numerous studies from as early as 1949 with the introduction of Dymond's Rating Test.

Historical Definitions of Empathy

With the development of Dymond's scale (1949) to measure empathic ability and relate this to the degree of insight a small group of students had in their interpersonal relations, came a definition of empathy as "the imaginative transposing of oneself into the thinking, feeling and acting of another and so structuring the world as he does" (Dymond, 1949, p. 127). This definition followed the work of others such as Lipps, Titchener, and Allport and implied an "apprehension of personal qualities or individuality of the other, not from a detached external view but from a position as participant-observer" (Barrett-Lennard, 1981, p. 91).

With the notion of knowing the other by experiencing and feeling as he does as explained by Adler (Barrett-Lennard, 1981), came a differentiation as noted by Rogers (1957) who described empathy as one of six necessary conditions for therapeutic personality change and stated the following:

> To sense the client's private world as if it were your own, but without ever losing the 'as if' quality--this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe. (p. 99)

Rogers believed that when the empathic condition occurred, the therapist was able to communicate to the client the therapist's understanding of what was occurring and he or she could also give meaning to experiences which were causing conflict for the client. The client may or may not have been aware of these meanings. Rogers saw the conditions (two persons in psychological contact, the client being in a state of incongruence, the therapist being in a state of congruence, the therapist exhibiting unconditional positive regard, the therapist experiencing empathic understanding, and the client receiving messages of this

understanding), as needing to be present before change could occur. Only the first condition could vary somewhat, and Rogers speculated that the degrees to which the other conditions were present might affect client outcome. Regarding the therapist's conditions, Rogers (1957) concluded that if the therapist did not have the necessary skills of unconditional positive regard, which he defined as "experiencing a warm acceptance of each aspect of that client" (p. 98); did not experience empathic understanding, and was not a "congruent, genuine, integrated person" (Rogers, 1957, p. 97), then he or she would need to learn these through experiential training.

In examining studies relating to Rogers' theory of what constitutes facilitative conditions for change to occur, Parloff, Waskow, and Wolfe (1978) found research failed to support this hypothesis and, in fact, noted that researchers have found that for some clients premature warmth and highly empathic statements resulted in patients becoming more anxious and defensive. However, these same researchers also noted discrepancies in these studies which failed to support Rogers' theories of facilitative conditions. Parloff et al. found that there were problems of specifying outcomes, rating judgements of individuals other than clients, and failure of individuals participating in helper roles to score at least minimally on levels of facilitative empathic communication (i.e., Level 3 on Carkhuff's scale).

As he worked with the concept and received feedback for his hypotheses, Rogers (1975) changed his notion of empathy as a state to empathy being a process. He noted that measuring empathy early in the counseling process could determine counseling outcome and, thus, reinforced the notion of empathy as being measurable with the results of these measures becoming a screening device for therapists who were likely to be unsuccessful.

Truax and Carkhuff (1967) added elements of responsiveness and communication to their definitions of empathy and stated the following:

> The focus is on the perceptive and communicative aspects of empathy, in which the therapist experiences the client's feelings as if they were his own, and communicates this perception in a way that the client can understand and work with. (p. 313)

Frequency of responses by the therapist, remaining distant in terms of separating therapist values, ideals, and standards of conduct from those of patients; responding in a personally intense and intimate manner to the patient, and expanding on the facilitative conditions first presented by Rogers were also extensively discussed by Truax and Carkhuff.

In looking at empathy, Deutsch and Madle (1975) noted the following:

> Several issues have not been clarified within an historic framework: whether an empathic response is a shared emotional experience, an understanding of affect, or both; whether an empathic response is a response to an object, another's affect, and/or circumstance; whether one process or several explain how one is empathic; and whether self-other differentiation is required by various other definitions of empathy. (p. 267)

The authors noted some tendencies of more accurate perceptions of others when the others were individuals of the same age and of the same sex. Whether this was the result of empathy or because of projection and identification was open to question. What did become clear, however, was that children who scored higher on empathy measures were less egocentric than children who did not score as well. Thus, the concept of empathy as a developmental process as outlined by the theories of Piaget was established, and this theory was reinforced by Feshbach (1975) who found developmental changes in empathy scores between children of different ages.

Historically, the research relating to empathy began to define this trait, quality, or characteristic as being made

up of a number of abilities such as perspective role-taking and empathic concern. Coke, Batson, and McDavis (1978) and Feshbach (1975) also concluded that empathy may be the result of interactions between cognitive and emotional factors. Feshbach (1975) noted the problems associated with empathy research by stating:

> A contributing factor to the widely contrasting conceptions of empathy may be a confusion between process and product. Thus, it is possible to conceptualize empathy as a cognitive product mediated by emotional factors or as an affective response mediated by cognitive processes. Further, by virtue of the complexity of social cognition and interaction, whereby products or responses acquire cue value and become incorporated into a feedback system, it becomes almost an arbitrary decision to specify the sequences of affect and cognition. (p. 25)

After reviewing the literature on empathy, Gladstein (1983) concluded that cognitive and affective empathy could be differentiated. He defined cognitive empathy as the process of "intellectually taking the role or perspective of another person" (Gladstein, 1983, p. 468), and noted that it involved "seeing the world as the other person does" (p. 468). Affective empathy was defined by Gladstein (1983) as "responding with the same emotion to another person's

emotion, that is, feeling the same way as the other person does" (p. 468).

In his study, Davis (1983) again briefly reviewed the literature and noted that empathy had been considered as being either a cognitive phenomenon focusing on intellectual processes such as perceiving accurately the other's perceptions, an emotional phenomenon focusing on emotional facets, or related to helping for which emotional reactivity appeared essential. He further stated that only by combining affective and cognitive components when looking at the empathic response could the understanding of empathy improve.

The Development of Empathy Measures

Gladstein (1983) noted that Dymond (1949) was influenced by the earlier work of Mead (1934) and Cottrell (1942) who focussed on role taking. The questions that Dymond asked when developing her scale related to whether or not empathy could be measured, how it related to age, what were the differences among individuals with regard to this concept, how did it relate to other factors such as intelligence, and what were the dimensions of this concept. Gladstein also noted that while Dymond's Rating Test was the first widely used role-taking empathy measure, it also received much criticism. Hastorf and Bender (1952) and Hogan (1969) questioned whether it was empathy or projection (in which the subjects own feelings are attributed to the

other) that was being measured as the differences between self and others were ambiguous. Chlopan, McCain, Carbonell, and Hagan (1985) reiterated this concern for projection and added the question of whether cultural stereotypes had influenced the interpretation of the data. Chlopan et al. and Hogan also noted the method for obtaining the empathy scores was cumbersome with administration time being in excess of two hours.

Deutsch and Madle (1975) noted that, in determining empathy, tests could be divided into two types. The first, predictive measures, related to accuracy of prediction of another's self-ratings or preferences. The second, situational measures, tended to assess either cognitive empathy, through identifying another's affect either alone in a particular situation, or affective empathy, by subjects describing another's feelings or by the subjects providing appropriate helping. The rating scale devised by Dymond (1949) was a predictive measure, as was the Empathy Test devised by Kerr and Speroff (1954). While the authors of the Empathy Test emphasized that it was "the first standardized empathy instrument with useful validity and reliability" (Kerr & Speroff, 1954, p. 274), Deutsch and Madle (1975) noted that there tended to be similar predictions for all individuals representing the norm group. In addition, Chlopan et al. (1985) noted that Kerr and Speroff's test failed to correlate with the Dymond empathy

test, and as for the claims of validity, Chlopan et al. found little support in the literature to show a consistency of results and questioned whether the Empathy Test actually did measure empathy.

Situational measures tended to use real contexts, photographs, line drawings, facial expressions, stories, audio recordings, and videotaped interaction sequences to determine a measure of empathy (Deutsch & Madle, 1975). The authors describe how these were used as follows:

> Typically, empathy is measured by having the subjects correctly label the contextual stimuli (e.g. Deutsch, 1974a) and/or the affective response portrayed (e.g. Borke, 1971; Deutsch, 1975) or by responding with a statement of action appropriate to a person's affective state (Danish and Kagan, 1971) or with a statement reflecting how the subject felt when observing another's affect in a setting (Feshbach and Roe, 1968). Changes in physiological responses (Stotland and Walsh, 1963); Vanderpool and Barratt 1970) or shared physiological conditions (Stotland et al., 1971) as a result of viewing affective situations also have been used. In all cases, however, standardized affectively-laden situations are used to assess an individual's perception of affective or situational stimuli. (p. 273)

While reliability seemed to be better on measures of situational measures, other problems such as inter-rater reliability, length of time for administration and problems with recordings emerged.

McWhirter (1973) noted that trained judges who complete ratings without all the visual clues such as body position and eye contact (which was the case when rating audiotapes) may result in the raters finding low levels of counselor-offered empathy compared to judges who have access to all available visual cues.

Other tests not mentioned but that appeared in the literature included the Hogan Empathy Scale (Hogan, 1969), which he reported as providing measures of social acuity and sensitivity to nuances in interpersonal behavior. Chlopan et al. (1985), in a review of the literature, found that the Hogan Empathy Scale had problems with reliability with some of the items actually having a negative correlation to total test score. The Accurate Empathy Scale (Truax & Carhkuff, 1967), which was reported as having validity difficulties (Barrett-Lennard, 1981) and problems of reliability estimates because of the use of nonindependent judgments (McWhirter, 1973), the Empathic Understanding Scale of the Relationship Inventory (Barrett-Lennard, 1981), for which therapist perceived empathy was found not to be a useful measure by Kurtz and Grummon (1972) and The Questionnaire

Measure of Emotional Empathy-QMEE (Mehrabian & Epstein, 1972), which was based on the premise that an individual who is highly emotionally empathic is less likely to engage in aggressive behavior and is more likely to engage in helping behavior when stress in another individual is noticed were other empathy measures reported.

Chlopan et al. (1985) noted that while empathy was generally believed to be negatively correlated to neuroticism, the QMEE showed some moderate relationship to this measure. They concluded in their study that both the QMEE and Hogan Empathy Scale appeared to have adequate validity but also appeared to be measuring two different aspects of empathy. The authors noted that Hogan's measure appeared to be more valid for males and seemed to be related to person perception, while the QMEE for Chlopan et al. seemed to be measuring vicarious emotional arousal and even a general tendency towards emotional arousal. Combining the QMEE and the Hogan Empathy Scale was purported to measure empathy as "the ability (a) to become emotionally aroused to the distress of another and (b) to take the other person's point of view" (Chlopan et al., 1985, p. 650).

Davis (1983) developed the Interpersonal Reactivity Index, IRI, which he based on a multidimensional approach. The IRI is described by Davis (1983) as follows:

> Rather than treating empathy as a single unipolar construct (i.e., as either cognitive or

> emotional), the rationale underlying the IRI is that empathy can best be considered as a set of constructs, related in that they all concern responsivity to others but are also clearly discernable from each other. The 28-item IRI is a self-report measure consisting of four 7-item scales, each tapping some aspect of the global concept of empathy. The Perspective-Taking (PT) scale assesses the tendency to spontaneously adopt the psychological point of view of others; the Fantasy (FS) scale taps respondents' tendencies to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays. The other two scales measure typical emotional reactions of the respondents: The Empathic Concern (EC) scale assesses "other-orientated" feelings of sympathy and concern for unfortunate others, and the Personal Distress (PD) scale measures "self-orientated" feelings of personal anxiety in tense interpersonal settings. (p. 113-114)

A total of 677 males and 667 females who were enrolled in introductory psychology classes at the University of Texas were used as the group for Davis' study. For the spring of 1979, 392 males and 378 females were enrolled in large group sessions when psychological tests and questionnaires were

administered. In the fall of 1980, 225 males and 235 females in a similar large group session were administered the IRI, the Hogan Empathy Scale, and the Mehrabian and Epstein Emotional Empathy Scale. The Wechsler Adult Intelligence Scale (WAIS) Vocabulary Test was also administered to 60 males and 54 females as part of a separate study and the results from this study were correlated with the scales on the IRI. Davis compared the relationships among the scales, between the scales, between other psychological measures and between the scales and existent empathy measures. His results showed predicted relationships among the scales and between other empathy measures were as he had expected.

One of the most significant of his findings, because of the implications it may have for the selection and screening of volunteers, related to the PD scale. He noted that "although unrelated to measure of intelligence, PD scores were strongly associated, as expected, with lower self-esteem and poor interpersonal functioning (especially shyness and social anxiety)" (Davis, 1983, p. 121). Becker and Sands (1988) noted studies that suggested inverse relationships between actual time spent in patients' rooms and the state of an individual's affective arousal and suggested further examination of the PD scale as a screening and testing device for recruiting and retaining nurses.

Davis (1983) also noted "the four qualities tapped by

the IRI are indeed separate constructs, each related in specific and specifiable ways with other psychological measures" (p. 123). Support for the theory behind the multidimensional approach and test developed by Davis was noted by Harman (1986) who stated that "rather than a unitary phenomenon, then, empathic responsivity is widely viewed today as a subtle and complex process involving cognitive, affective and communicative dimensions" (p. 371).

The Changing Role of Volunteers

Zimmerman (1981) described the needs of services in palliative care settings such as hospices as being labour intensive and, therefore, costly. In order to provide the essential services required to meet the necessary standards and objectives of hospice programs, while maintaining reasonable costs and ensuring quality care, volunteers who would work with professionals were introduced.

This relationship was seen as being different from the past where volunteers often had duties such as filing, typing, answering phones, and other tasks not directly involving contact with patients (Heilig, Farberow, Litman, & Shneidman, 1968); and the type of service that was now being offered was a relatively new concept (Relf & Couldrick, 1988). Because of their close personal contacts with patients and their families, volunteers needed to be committed to the task. Professionals, in turn, had to be confident that volunteers "would not turn away from

unrelieved pain" (Jolley, 1988). Related to, and part of this, was also the need to know both how the volunteer would react in problem situations and what his or her motives for volunteering were (Heilig et al., 1968; Howarth, 1984; Markey, 1980; Rossing 1988). This was because of possible harmful effects from individuals acting on the basis of values that were incongruous to a program's needs (Knowles, 1979), and the possible loss of security and resultant self-esteem to patients because of volunteers who leave a program before their commitment time has elapsed.

It was also determined that one of the essential qualities that a volunteer must have was empathy. This was because empathic volunteers tended to be better at reaching the patient (Clay, 1984; Tyner, 1985), that volunteers who were judged to be empathic also proved to exhibit a number of other personality characteristics that seemed to be found in successful volunteers (Rogers, 1957; Wilkinson & Wilkinson, 1986), and that there were some implications for successful training of individuals who had higher empathy scores (Steibe et al., 1979).

Summary of the Literature

When the term "empathy" was first defined for measures that were developed to test this quality in individuals (such as those by Dymond, 1949, and Kerr and Speroff, 1954), researchers questioned whether empathy or projection and cultural stereotypes were actually influencing the results

(Chlopan et al., 1985; Hastorf & Bender, 1952; Hogan, 1969). Empathy then came to be defined as a process (Rogers, 1975), and later, this process was considered by many to be developmental with groups identifying more readily with members of their own group (Deutsch & Madle, 1975; Feshbach, 1975). In studies of young children, Feshbach (1975) and Iannotti and College (1975) found correlations between high levels of empathy and prosocial behavior (such as altruism and lowered levels of aggression), the likelihood of higher empathic scores between similar subjects (on variables such as age, sex and race), and the increase of empathic responses with age.

Measures that developed from the definitions of empathy tended to differentiate between cognitive (intellectual role-taking) and affective empathy (feelings of another's emotions) as noted by Gladstein (1983); and the tests were either classified as predictive (judging another's self-ratings accurately), or situational (judging another's affect with or without context, describing another's feelings, or having subjects provide appropriate helping) with situational tests seeming to show more reliability (Deutsch & Madle, 1975). Despite this, situational tests also seemed to display problems with inter-rater reliability, length of administration time, and technical problems such as clarity in recordings and voice quality (Deutsch & Madle, 1975).

Finally, researchers concluded that either more than one aspect of empathy was being measured (Chlopan et al., 1985), or that because it is a process (seen as developmental by Deutsch and Madle, 1975), different stages of the process were measured; or that empathy was an interaction of cognitive and emotional factors (Coke et al., 1978; Feshbach, 1975). This was Davis'(1983) rationale for the development of the Interpersonal Reactivity Index (IRI) which was a self-report measure. The PD scale seemed to be of particular relevance to the screening of volunteers as it provided a measure of self-esteem and interpersonal functioning. Scores on this scale were purported by Davis to indicate those individuals who had poor self-esteem, were shy and were anxious in social situations. Accordingly, individuals who scored low on this scale would be more likely to possess traits such as charm, friendliness, and tact that Hogan (1969) correlated to individuals who scored high on his empathy measure.

Implications For Screening Volunteers

A study of the literature indicated that the measure provided by Davis (1983), the IRI, could prove to be an effective instrument in measuring empathy as it incorporated a multidimensional approach. In terms of screening for volunteers for palliative and health care programs, the PD scale showed possibilities for determining individuals not

suitable for volunteering. However, by itself, the IRI, and specifically the PD scale, was not sufficient for showing how individuals interested in palliative care and related health fields would react when encountering problem situations that would arise in this area. How a person felt about death, how committed they were to staying with a patient in constant pain, how able volunteers were to express concern while still remaining distanced enough to be of assistance to the patient, and how individuals were able to communicate their caring (not sympathy) to the individual were all key issues that needed to be addressed.

Because Carkhuff (1969) viewed the helping process as being interactive with the person being helped providing feedback and the person doing the helping either facilitating or retarding the interactions which occurred, Carkhuff reiterated the need to identify the variables which contributed to or inhibited positive movement in the helping process. Thus, Gladstein's (1983) comments regarding the need to know whether a person's emotional reaction will be facilitative to helping was an important consideration for a measure for volunteer screening.

Implications for Defining Empathy

By combining the statements of Davis (1983), Deutsch and Madle (1975), Feshbach (1975), Rogers (1957), Taft (1955) and Truax and Carkhuff (1969) empathy could be defined as a multidimensional set of constructs that are

separate from each other (either as observable entities or as different steps of a process) but related to each other (in that they are part of the same process or that all entities combined to affect outcome of interactions). This process was viewed as being developmental in nature and was affected by experiences or learning brought to the task and by the interactions that occurred. These interactions were seen as continually determining outcomes of helping by providing feedback and altering or continuing perceptions that were occurring between participants. To be empathic would mean to be highly motivated and able to remain somewhat detached but willing to perceive the other's emotional responses, values, and beliefs; and able to communicate this perception. While attempts have been made to separate different aspects of empathy (affective versus cognitive, situational versus predictive), a more likely hypothesis might be that empathy is the sum total of these constructs. What an individual brings to the task, how they perceive, define and act on a problem presented by another individual, and what the outcome is would determine whether the empathic process is continued or discontinued. To measure the level of empathy, Truax and Carkhuff (1967) noted that what could be observed was the communication that was occurring between the helper and helpee. Thus, it was possible to note the therapist's level of response to statements made by an individual in need of assistance. An

instrument that could effectively measure this level of response within the palliative care setting would be an asset in the selection and possible training of volunteers, and as such, the VET was developed.

CHAPTER III

Procedure and Design

To develop and establish initial reliability and validity for the Volunteer Empathy Test (VET), this study was divided into five components: item construction, item selection, "expert" item validation, contrasting group validation, and test-retest reliability.

Item Construction

Initially, contact was made with several volunteer coordinators (Palliative Care Coordinating Council) involved in hospital settings to determine the viability of a research project intended to develop the VET. Strong support for this project was provided at an inter-agency meeting of Volunteer Coordinators from within the Greater Edmonton area.

In order to develop a situation specific measure pertaining to a hospice setting, arrangements were first made for the researcher to observe and interact with staff, volunteers and patients of a palliative care unit located at the Edmonton General Hospital. This created familiarity of the researcher with the setting for which volunteers were being trained and also provided the genesis of actual questions to be used in the VET. In addition, a set of

patient statements outlining typical concerns of those patients were obtained from a researcher in another Edmonton area hospital (Cross Cancer Institute) concerned with cancer patients.

Using a multiple choice format, 75 situations specific to patient circumstances in a hospice or palliative care unit were developed. Approximately 90% of these situations were drawn from actual patient statements made to either a researcher or a volunteer who was later interviewed by this researcher.

Three potential empathic responses to each of the 75 patient situations were then developed. The use of three-option multiple choice items was supported by recent studies (Costin, 1970; Kolstad, Kolstad, & Wagner, 1986; Owen & Froman, 1987). These responses were limited to one sentence each. Rules regarding construction of fair and equal sentence stems (Aiken, 1987; Schrock & Mueller, 1982) were followed to ensure equality between responses, thereby eliminating potential guessing by those completing the test. The three options reflected varying levels of communicated empathy, using Carkhuff's Empathic Understanding in Interpersonal Process Scale (1969) as a model. While all levels of Carkhuff's scale were utilized in stem construction, the three options for each stem were generally designed to correspond to each of Carkhuff's Level 1, 3, and 5 items of his scale. Level 1 responses were indicative of

either a 0 response or a detraction from the expression of the client, while level 3 responses were interchangeable with the client's, and level 5 responses were able to give meaning to the client's confusion (Carkhuff, 1969; Kurtz & Grummon, 1972). An example of a question stem and level 1 response used was, STEM-"This home care nurse was here this morning. She talked to me about dying at home. But what about the pain?" RESPONSE-"Maybe it would be more comforting to you to stay in the hospital."

Using Fry's Readability Formula (1977), questions and response statements were analyzed and judged to be at a grade 3 reading level. These results were verified by a reading specialist.

Five individuals with varying levels of education and different occupations were then asked to complete the questions and to offer critical comments regarding any aspect of each question as well as to offer their overall impressions. Appropriate modifications to questions were then made. Approximately ten questions were altered to improve clarity, correct grammar, and spelling errors, or to simplify reading levels.

The final questions were then submitted to the Ethics Committee of the Department of Educational Psychology, University of Alberta, for approval, along with a copy of an approved proposal relating to their use. This approval was obtained.

Item Selection

The preliminary item selection stage involved the administration of the 75 items as well as the Interpersonal Reactivity Index (Davis, 1983) to a large pool of non-selected individuals. The IRI was chosen on the basis of Davis' view of empathy as a set of cognitive and affective constructs including fantasy role taking, perspective taking, empathic concern, and personal distress; apparent strong psychometric properties; and ease of administration and scoring (Davis, 1983). Davis (1980) described his instrument as having the following characteristics:

> First, it has excellent psychometric properties. The factor structure remains constant for both sexes across independent samples and across repeated administration. In addition, the internal reliability of the four scales is quite acceptable. Second, the pattern of sex differences found for the four scales is consistent with the general pattern found in empathy research. Females score substantially higher than males on the measures of emotional reactivity (including the fantasy scale), and less strongly so on the scale most clearly measuring perspective-taking ability. Finally, the relationships found to exist among these scales also support previous theorizing about the development of empathic tendencies (Hoffman, 1976). That is, greater perspective-taking ability is

> associated with greater feelings of empathic concern for others and less feelings of personal unease in the face of others' negative experiences. The new instrument therefore appears quite well-suited for use as a research tool in studying empathy, and especially useful in investigations of the multidimensional nature of the empathic process. (p. 14)

The research sample was obtained from a number of undergraduate classes on campus at the University of Alberta. Students from ten classes ranging in size from 11 students to 75 agreed to participate in the study. All classes were from the Faculty of Education, with the majority being in Educational Psychology. Eight professors agreed to relinquish up to 40 minutes of class time at the end of a regularly scheduled class to allow those students who wished to participate in the study to complete it. All other students were given permission to leave the class early. One professor allowed three of his classes to participate in the study. All data for this segment of the study were gathered during a two week period of time between January 15, 1990 and February 3, 1990. Students were provided with both written and verbal instructions. Instructional information assured anonymity of the subjects, informed them of their voluntary commitment and the extent of this commitment, and provided an offer to share final results regarding the general outcome of the study when the

research was completed.

Demographics regarding this sample are described later under Sample Description of Group A. All subjects were chosen on the basis that they had not likely completed any specific course work regarding either empathy or communication skills. These subjects formed group A.

Sample Description of Group A

Three hundred and eighty one students completed the initial measure consisting of 75 items as well as the 28 item IRI. Tables 1 through 3 indicate specific data regarding subjects. There were no significant differences between males and females in terms of age, marital status, or education. Ninety three males and two hundred and eighty eight females with a mean age of twenty five completed the initial measure (Table 1).

Table 1

Means and Standard Deviations of Ages of Respondents Completing the 75 Item Volunteer Empathy Test

Gender	N	X	SD
Male	93	25.30	7.12
Female	288	25.06	7.61

Table 2

Educational Status of Respondents Completing The 75 Item Volunteer Empathy Test

Educational Status-Years of Education After Grade 12	Males Count	Females Count	Row Total
0	3	4	7 1.9%
1	8	40	48 12.6%
2	19	58	77 20.2%
3	48	120	168 44.1%
4	11	57	68 17.9%
5	4	9	13 3.4%
Column Total	93 24.4%	288 75.6%	381 100.0%

Table 3

Marital Status of Respondents Completing The 75 Item Volunteer Empathy Test

Marital Status	Males Count	Females Count	Row Total
Single	63	186	249 65.7%
Married	25	54	79 20.8%
Living Commonlaw	2	19	21 5.5%
Separated or Divorced	3	17	20 5.3%
Widowed	0	2	2 .5%
Other	0	8	8 2.1%
Column Total	93 24.5%	286 75.5%	379 100.0%

Ninety five percent of students were completing undergraduate studies (Table 2). Two thirds of group A were single, having never been married (Table 3).

Statistical Procedures for Group A

All data were analyzed using the Statistical Package for Social Sciences-Revised (SPSS-X).

Both the individual score on each item and the total score for the entire 75 items were recorded. For each of the three sentence responses to each item a score of either 1 (low empathic), 3 (moderate empathic) or 5 (high empathic) was assigned. Subjects received a score for each question according to the level of response chosen. Each subject received a total score by summing the responses on all the questions. Thus the total score could range from a low of 75 to a high of 375. Item-to-total score correlations (not including the item itself) were calculated. Those items that showed a correlation of at least >+.4 (generally considered to be a conservative level of positive correlation) were retained for the next phase of testing. The 30 items demonstrating the highest positive correlations were to be selected. These items would then form the Volunteer Empathy Test (VET).

In addition, Pearson product correlation coefficients were calculated for educational level, marital status, age, VET total (75 item measure) and the four scales of the IRI.

Expert Item Validation

To establish validity that questions being utilized in the VET provided a range of empathic responses, five clinicians currently practising in palliative care units were identified by a committee of three versed with both the study and concepts of empathy. These clinicians were judged by the committee to possess knowledge of palliative care units and to possess empathic skills. The clinicians were asked to complete, independently, each of the 30 questions of the VET, following the directions outlined. In addition, the clinicians were asked to note which response they were "least likely to make." Only those questions where at least 80% agreement between the five clinicians regarding the level of empathy of sentence stems was obtained, would be retained and form the final version of the VET. After this process 24 questions remained and formed the final version of the VET.

Contrasting Group Validation

To validate the VET, contrasting groups completed the 24 item test, comprised of questions chosen from the original 75 items.

These contrasting groups were chosen on the basis of being either "high empathic" or "low empathic." High empathic individuals were likely to have completed formal training in communication skills including the use of empathy. This group was identified as group B and

consisted of individuals from the following employment or education groups:

1. Counseling psychologists
2. Educational psychology graduate students (counseling)
3. School counselors
4. Senior level nursing students
5. Experienced hospital volunteers or nurses

Generally, psychologists, graduate students, school counselors, and experienced hospital volunteers or nurses received training in either communication skills or empathy (Review of course requirements, Faculty of Graduate Studies, Department of Educational Psychology, 1989; Review of training procedures with Coordinators of hospital volunteer training programs, 1990). Bergman (1983) and Clay (1984) reported empathy training with nurses.

Consent was obtained from the Faculty of Nursing to access the senior level nursing students.

Low empathic individuals were unlikely to have received any formal training in communication skills and were not likely to be aware of the concept of empathy. Low empathic subjects were originally to have been drawn from a prison population but access to this population proved to be very difficult. Representatives from provincial and federal prison systems were contacted requesting permission to access inmates for voluntary participation. Protection of

inmates' rights, lack of relevance to the day-to-day world of the inmates and generally described apathy of most inmates towards research were reasons provided for denial of access. Kaplan and Arbuthnot (1985) noted that delinquent populations are significantly less empathic than nondelinquents. Unfortunately, by their very definition, low empathic subjects were difficult to access because of their general unwillingness to participate in the study.

Low empathic subjects were eventually drawn from a population identified by Kerr and Speroff (1954) who found no correlation between sales clerks and empathy utilizing the Empathy Test. They speculated that there was no "relative importance of empathic ability in across-the-counter selling" (p. 274). Thus a group of sales clerks from a clothing store chain with a number of retail outlets in the Edmonton area was chosen.

The low empathic subjects were defined as group C.

All subjects from group B and group C also completed the IRI to allow for examination of correlations between the IRI and the VET. The questionnaire was structured such that the IRI was completed first, followed by the VET.

All subjects in groups B and C completed assigned questionnaires for this component of the study between February 4, 1990 and February 18, 1990.

Sample Description of Group B

Counseling psychologists were chosen from a large private practice firm located in the City of Edmonton. All subjects had completed at least their Master's Degree in Psychology or Counseling Psychology. Subjects agreeing to participate in the study were given the IRI and the VET to complete. Throughout all questionnaires, the IRI was completed first, followed by the VET. Ten subjects were administered the questionnaire.

Graduate educational psychology counseling students were obtained from two classes of Educational Psychology 512. Professors involved relinquished part of a regular class in order to allow volunteering participants to complete the measure. Twenty students completed the questionnaires.

School counselors were solicited with the assistance of the coordinator of school counselors for the Edmonton Public School Board. The coordinator was directed to put forth names of subjects thought to be high in empathy. The IRI and VET were personally delivered to subjects agreeing to participate in the study. Completed measures were then picked up by the researcher when completed. Eleven subjects completed the tests.

Senior level nursing students who agreed to volunteer as subjects for the study were assessed as part of their regular class time which their instructor agreed to

relinquish. The IRI and VET were completed during a twenty five minute sitting. Forty subjects completed the measures.

Practising experienced hospital volunteers and nurses from nine area hospitals and extended care programs completed the IRI and VET which were delivered through a meeting of volunteer coordinators who kindly agreed to distribute the tests. The coordinators had been asked to identify volunteers or nurses whom they felt were highly empathic. The questionnaires were then retrieved from each setting by the researcher. Thirty subjects from this group completed the measures.

Sample Description of Group C

Group C subjects were obtained with the consent of management of a large national retail chain employing several hundred employees. Subjects were drawn from the Edmonton area retail stores. This firm offers minimal training, has little, if any, opportunity for advancement and pays minimum wage. Management indicated their support for the research directly to employees in each retail store but would not allow for one testing session with all volunteer subjects present. This would have necessitated closure of some of the retail outlets for a substantial period of time. Employees who volunteered were expected to complete the measure on their own time or during "quiet" times during the normal operation of the retail outlet. Generally, the questionnaire was completed within the next

three days after the subject agreed to complete it. Thirty one subjects completed the questionnaire.

Tables 4 through 7a inclusive provide demographic data regarding the 142 subjects from groups B and C who completed the questionnaire.

Statistical Procedures for Groups B and C

All data were analyzed using the Statistical Package for Social Sciences-Revised (SPSS-X).

Pearson product correlations coefficients were calculated for educational level, marital status, age, group, VET total (25 item measure) and the four subscales of the IRI. Cronbach alpha coefficients were calculated for the VET as well as four scales of the IRI. One way analysis of variance procedures were also completed on groups comparing VET scores as well as each of the IRI scales. The Scheffe test for multiple comparison of means was employed where the analysis of variance was significant.

Test-Retest Reliability

To help establish test-retest reliability of the VET, subjects from the high empathic group B and subjects from the low empathic group C were asked to complete the VET (24 item) and IRI on a second occasion, approximately 3 to 4 weeks after initial testing. All participants had been informed at the time of the initial testing session that they may be asked to complete a second questionnaire approximately one month after the first.

Table 4

Crosstabulation of Gender By Group Completing the 24 Item Volunteer Empathy Test

Group	Males Count	Females Count	Row Total
Psychologists (Group B)	8	2	10 7.0%
Counseling Graduate Students (Group B)	2	18	20 14.1%
School Counselors (Group B)	5	6	11 7.7%
Nursing Students (Group B)	5	35	40 28.2%
Hospital Volunteers (Group B)	6	24	30 21.1%
Retail Sales Clerks (Group C)	3	28	31 21.8%
Column Total	29 20.4%	113 79.6%	142 100.0%

Table 5

Means and Standard Deviations of Ages of Respondents Completing the 24 Item Volunteer Empathy Test

Group	N	X	SD
Psychologists (Group B)	10	38.40	7.32
Counseling Grad Students (Group B)	20	31.90	7.41
School Counselors (Group B)	11	43.55	8.95
Nursing Students (Group B)	40	24.70	5.18
Hospital Volunteers (Group B)	30	45.50	14.64
Retail Sales Clerks (Group C)	31	27.68	9.31

Table 6

Educational Status of Respondents Completing The 24 Item Volunteer Empathy Test

Educ. Status	Psych	Grad Sts.	School Couns.	Nursing Sts.	Hospital Volunteers	Sales Clerks
Gr 9 or < (2)	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	2 100.0
Gr 10-12 (28)	0 0.0	0 0.0	0 0.0	2 7.1	9 32.1	17 60.8
Undergrad (69)	0 0.0	0 0.0	2 2.9	38 55.1	18 26.1	11 15.9
Masters (38)	6 15.8	19 50.0	9 23.7	0 0.0	3 7.9	1 2.6
Doctorate (5)	4 80.0	1 20.0	0 0.0	0 0.0	0 0.0	0 0.0
Col (142) Total(100%)	10 7.0	20 14.1	11 7.7	40 28.2	30 21.1	31 21.8

Table 7a

Marital Status of Respondents Completing The

24 Item Volunteer Empathy Test

Marital Status	Psych	Grad Sts.	School Couns.	Nursing Sts.	Hospital Volunteers	Sales Clerks
Single (55)	1 1.8	7 12.7	2 3.6	27 49.1	6 10.9	12 21.8
Married (59)	8 13.6	8 13.6	8 13.6	6 10.2	19 32.2	10 16.9
Commonlaw (12)	1 8.3	1 8.3	0 0.0	5 41.7	1 8.3	4 33.3
Sep/Div. (15)	0 0.0	4 26.7	1 6.7	2 13.3	3 20.0	5 33.3
Widowed (1)	0 0.0	0 0.0	0 0.0	0 0.0	1 100.0	0 0.0
Col (142) Total(100%)	10 7.0	20 14.1	11 7.7	40 28.2	30 21.1	31 21.8

Sample Description For Test-Retest

Twenty subjects from the senior nursing students and ten subjects from the low empathic group agreed to complete the second questionnaires. All testing was completed between March 7, 1990 and March 12, 1990. Data from this testing were then compared with initial questionnaire results for each subject.

CHAPTER IV

Findings and Conclusions

Introduction

This study examined initial reliability and validity for a newly constructed multiple choice measure of empathy. Original test items were composed from cancer patient and palliative care patient questions and researcher responses, based on Carkhuff's Empathic Understanding in Interpersonal Process Scale (1969). From a beginning pool of 75 potential test items, 30 were chosen where the item to total coefficient was >+.4 after a sample of 381 university students was administered the questionnaire. Next, five experts in the areas of palliative care and empathy completed the 30 item questionnaire. The six multiple choice questions with answers having less than .8 levels of agreement between the five raters were eliminated from the question pool. The remaining 24 items formed the Volunteer Empathy Test (VET). The VET, along with the Interpersonal Reactivity Index (IRI), was administered to contrasting groups: high empathic and low empathic individuals. A comparison of mean scores on the VET and all scales of the IRI for both groups was then completed. Finally, in order to establish test-retest reliability, a small sample of high and low empathic group members were readministered the VET

and IRI approximately three to four weeks after initial testing.

Results are reported in this chapter.

Group A Results

Item to Total Correlations

For the 75 item questionnaire, an alpha coefficient of .92 was calculated. Calculating an item to total correlation not including the item itself, for these same items yielded results as tabulated in Table 7b. Those items with a correlation of >+.4 (as generally accepted within statistical procedures) were then accepted as items used to form the Volunteer Empathy Test. Thirty items qualified for inclusion in the VET. Item to total correlations for the 30 items ranged from .42 to .61.

In addition, item to total correlations were calculated for each of the IRI scales and are reported in Tables 8 to 11. Of note was the relatively low correlations for items 1 (.28), 3 (.37), 10 (.37), and 13 (.39). Alpha reliability coefficients ranged from .77 to .80 for the four scales.

After choosing the 30 items from the original pool of 75 which met the required minimum >+.4 item to total correlation, an item to total correlation not including the item itself, was recalculated on these extracted 30 items. These correlations remained above +.4 for all questions and ranged from .42 to .62. These results are reported in Table 12.

Table 7b

Item To Total Correlation (r)

For 75 Item Questionnaire (Group A)

Ques. No.	r	Ques. No.	r	Ques. No.	r	Ques. No.	r	Ques. No.	r
1.	.33	16.	.20	31.	.38	46.	.61	61.	.50
2.	.45	17.	.16	32.	.17	47.	.51	62.	.12
3.	.38	18.	.35	33.	.28	48.	.36	63.	.45
4.	.40	19.	.50	34.	.54	49.	.31	64.	.46
5.	.53	20.	.51	35.	.54	50.	.52	65.	.32
6.	.55	21.	.42	36.	.32	51.	.48	66.	.12
7.	.08	22.	.15	37.	.42	52.	.20	67.	.34
8.	.18	23.	.30	38.	.18	53.	.47	68.	.23
9.	.47	24.	.34	39.	.31	54.	.38	69.	.11
10.	.06	25.	.10	40.	.30	55.	.38	70.	.28
11.	.43	26.	.02	41.	.11	56.	.35	71.	.52
12.	.54	27.	.14	42.	.48	57.	.52	72.	.52
13.	.20	28.	.44	43.	.45	58.	.43	73.	.36
14.	.22	29.	.43	44.	.43	59.	.22	74.	.15
15.	.19	30.	.22	45.	.31	60.	.40	75.	.61

Table 8

Item To Total Correlation (r)

For Perspective Taking Scale (Group A)

Question Number	Correlation Coefficient (r)
3.	.37
8.	.63
11.	.48
15.	.44
21.	.60
25.	.58
28.	.57

Table 9

Item To Total Correlation (r)

For Fantasy Scale (Group A)

Question Number	Correlation Coefficient (r)
1.	.28
5.	.51
7.	.50
12.	.56
16.	.59
23.	.64
26.	.63

Table 10

Item To Total Correlation (r)

For Empathic Concern Scale (Group A)

Question Number	Correlation Coefficient (r)
2.	.47
4.	.42
9.	.47
14.	.50
18.	.53
20.	.53
22.	.52

Table 11

Item To Total Correlation (r)

For Personal Distress Scale (Group A)

Question Number	Correlation Coefficient (r)
6.	.51
10.	.37
13.	.39
17.	.41
19.	.63
24.	.58
27.	.58

Table 12

Item To Total Correlation (r)

For 30 Item Questionnaire (Group A)

Question Number	Correlation (r)	Question Number	Correlation (r)
2.	.42	43.	.46
5.	.54	44.	.50
6	.55	46.	.60
9.	.50	47.	.52
11.	.44	50.	.51
12.	.55	51.	.48
19	.50	53.	.49
20.	.52	57.	.51
21.	.42	58.	.44
28.	.43	61.	.49
29.	.42	63.	.46
34.	.54	64.	.45
35.	.53	71.	.54
37.	.42	72.	.54
42.	.47	75.	.62

Pearson Correlation Coefficients

Pearson correlation coefficients examining relationships between education, marital status, age, IRI scales and the 75 item VET were calculated.

There were positive correlations demonstrated between the Empathic Concern Scale of the IRI and the Perspective Taking and Fantasy Scales, also of the IRI. These relationships were reported by the author of the IRI (Davis, 1983). There was a demonstrated relationship between the Personal Distress Scale and the Fantasy Scale of the IRI. This would indicate that for group A, the more an individual was experiencing personal distress, the more fantasy role-taking was engaged in by the individual.

Finally, there was a relationship suggested between VET scores and age. This would suggest that as one gets older, VET scores increase.

When Pearson correlation coefficients were calculated on data from the 30 questions selected from the original group A pool of 75 questions little change in correlations between variables was noted. Table 13 reports this information.

Table 13

Matrix of Correlation Coefficients Between VET, IRI Scales, and Demographic Variables for Group A (30 Item)

	Educ	MS	Age	VET	PT	FS	EC
Educ							
MS	.02						
Age	.26**	.48**					
VET	.01	.18**	.26**				
PT	-.07	.12**	.06	.16**			
FS	-.10*	-.03	-.13**	.11**	.15**		
EC	-.11*	.05	-.02	.16**	.38**	.30**	
PD	-.07	-.15**	-.14**	-.14**	-.19**	.30**	.04

* p=.05
** p=.01

Abbreviations: VET=Volunteer Empathy Test, PT=Perspective Taking Scale, FS=Fantasy Scale, PD=Personal Distress Scale

Gender Differences

In order to examine the gender differences for the IRI scales and the VET in group A, a two tailed t-Test was completed which provided the results documented in Table 14. Scores on the VET and three of the four IRI scales indicated that mean scores for females were significantly higher than for males ($p=.01$). The Perspective Taking Scale showed no difference between males and females. Davis'(1983) ability of respondents to adopt the psychological point of view of others showed no difference between males and females.

Expert Item Validation

Expert Inter-Rater Reliability

To assist in further establishing reliability and validity for the VET, five independent raters, chosen by a committee familiar with the study as possessing expertise in both the areas of palliative care and empathy, completed the 30 item VET. Four raters were currently employed as psychologists at the Cross Cancer Institute while one was currently employed in another hospital setting as a nursing instructor. Only those questions with inter-rater reliability of 80% agreement or higher on choices of high empathic and low empathic responses were considered reliable enough to remain as part of the VET. For each question, responses of each expert were compared, and where at least four of the five raters matched responses, the questions were considered acceptable. Table 15 provides this

Table 14

Two Tailed t-Test Results of Gender Differences For IRI Scales and VET (Group A)

Var	Group	N	X	SD	t	df	p
PT	Male	93	17.31	4.62	-2.01	379	.05
	Female	288	18.40	4.50			
FS	Male	93	16.03	5.36	-4.70	379	.01
	Female	288	18.89	5.00			
EC	Male	93	19.67	4.25	-5.00	379	.01
	Female	288	22.01	3.84			
PD	Male	93	9.57	4.19	-4.08	379	.01
	Female	288	11.85	4.85			
VET	Male	93	74.89	25.21	-4.14	379	.01
	Female	288	88.56	28.46			

Abbreviations: PT=Perspective Taking Scale, FS=Fantasy Scale, EC=Empathic Concern Scale, PD=Personal Distress Scale, VET=Volunteer Empathy Test

Table 15

Inter-rater Reliability For
Expert Clinicians

Question	Reliability Coefficient	Question	Reliability Coefficient
1.	1.0	16.	.8
2.	.6	17.	.6
3.	1.0	18.	1.0
4.	.6	19.	1.0
5.	1.0	20.	1.0
6.	1.0	21.	1.0
7.	.8	22.	1.0
8.	1.0	23.	1.0
9.	.6	24.	.8
10.	1.0	25.	.6
11.	1.0	26.	1.0
12.	1.0	27.	.8
13.	1.0	28.	1.0
14.	1.0	29.	.6
15.	1.0	30.	1.0

information. Twenty four questions reached the required criterion and formed the final version of the VET.

Contrasting Groups-Groups B and C

Subgroup Analysis

A basic assumption of group B was that all subjects forming this group would be high empathic. Because of the diverse educational and experiential backgrounds of each subgroup of group B (counseling psychologists, educational psychology graduate students in counseling, school counselors, senior level nursing students, experienced hospital volunteers or nurses) a one way analysis of variance test was completed examining significant differences between mean scores on the VET (final version, 24 item test) and each of the subgroups as well as group C. The Scheffe post-hoc test was used to further investigate significant main effects. There was a significant difference between group C and all other subgroups of group B at the .05 level, with group C being lower. There was a significant difference among subgroups of B between the subgroup of experienced volunteers and nurses and the subgroups of both the practising psychologists and graduate counseling students, but as with other subgroups of B, the mean scores of each of these groups still differed from group C. The mean scores from the subgroup of experienced volunteers and nurses were statistically lower than the other two subgroups. These results suggested that the

subgroups in B could be treated as a singular group in terms of their consistent, statistically significant, difference from group C.

Results from the one way analysis of variance are reported in Table 16.

Item To Total Correlations

Item to total correlations, not including the item itself, for both group B and group C were calculated for the 24 item VET and each of the seven item scales of the IRI (Perspective-Taking, Fantasy, Empathic Concern, and Personal Distress). Item to total correlations for the VET were increased over the group A scores, probably as a result of the elimination of statistically weaker items from the original item pool. A Cronbach Alpha coefficient of .94 was calculated. Item to total correlations ranged from .41 to .81. Specific VET item to total correlations are outlined in Table 17.

Item to total correlations for IRI scale items ranged from .28 to .67 and were generally lower than those of the VET and initial correlations obtained from testing with group A, with the exception of the Personal Distress Scale. The Personal Distress Scale item to total correlations were stronger and ranged from .41 to .67. Tables 18 to 21 outline specific item to total correlations for each of the four IRI scales.

Table 16

Summary of Scheffe Post-Hoc Results For VET and Subgroups of Group B and Group C

Group	$\bar{X}$	Grp C	Vol/ Nurse	Schl Coun	Nurse Sdnt	Grad Coun	Psych
Group C	52.81						
Volunteers And Nurses	85.73	*					
School Counselors	90.55	*					
Sr. Nursing Students	97.35	*					
Grad. Couns. Students	106.40	*	*				
Counseling Psychologists	107.60	*	*				

* Denotes significant group differences between the pairs at the .05 level

Table 17

Item To Total Correlation (r)

For 24 Item VET Questionnaire (Groups B and C)

Question Number	Correlation (r)	Question Number	Correlation (r)
2.	.73	43.	.51
6	.69	46.	.69
11.	.41	47.	.61
12.	.61	50.	.76
19.	.62	51.	.46
20.	.60	53.	.75
28.	.66	57.	.68
29.	.58	58.	.57
34.	.55	63.	.64
35.	.67	64.	.67
37.	.54	71.	.66
42.	.51	75.	.81

Table 18

Item To Total Correlation (r)

For Perspective Taking Scale (Groups B and C)

Question Number	Correlation Coefficient (r)
3.	.40
8.	.44
11.	.53
15.	.37
21.	.54
25.	.46
28.	.35

Table 19

Item To Total Correlation (r)

For Fantasy Scale (Groups B and C)

Question Number	Correlation Coefficient (r)
1.	.28
5.	.65
7.	.49
12.	.55
16.	.63
23.	.60
26.	.56

Table 20

Item To Total Correlation (r)

For Empathic Concern Scale (Groups B and C)

Question Number	Correlation Coefficient (r)
2.	.48
4.	.29
9.	.35
14.	.39
18.	.46
20.	.37
22.	.49

Table 21

Item To Total Correlation (r)

For Personal Distress Scale (Groups B and C)

Question Number	Correlation Coefficient (r)
6.	.50
10.	.42
13.	.41
17.	.54
19.	.67
24.	.64
27.	.62

Reliability of items comprising the VET were demonstrated by scores from group B and C testing. Similarly, IRI items, particularly on the Perspective-Taking and Empathic Concern Scales were less reliable than the VET and results from testing with contrasting groups would suggest weakened reliability of IRI items, although still within acceptable limits.

Comparison of VET Means For Groups B and C

A comparison of group means for the VET scores of the high empathic (group B) and low empathic (group C) groups yielded results which indicated statistically significant differences between these groups. Group B had a total mean VET score higher than group C (Table 22).

Comparison of IRI Means For Groups B and C

Significant group mean differences were also demonstrated for two scales of the IRI: Perspective Taking and Personal Distress. When compared to group C, group B scored significantly higher on the Perspective Taking Scale of the IRI, and significantly lower on the Personal Distress Scale (Table 22).

Pearson Correlation Coefficients

Groups B and C Combined

Pearson correlation coefficients exploring the relationships between the VET, age, and four scales of the IRI for combined group B and group C were also calculated and are reported in Table 23. Age was negatively correlated

Table 22

Two Tailed *t*-Test Results of High Versus Low Empathic Groups For IRI Scales and The VET

Var	Group	N	X	SD	t	df	p
PT	High	111	19.70	4.19	2.38	140	.02
	Low	31	17.68	4.21			
FS	High	111	16.45	6.17	-0.82	140	.41
	Low	31	17.45	5.29			
EC	High	111	21.56	3.90	0.05	140	.96
	Low	31	21.52	5.12			
PD	High	111	9.33	4.78	-4.69	140	<.001
	Low	31	14.16	6.00			
VET	High	111	96.09	15.38	12.52	140	<.001
	Low	31	52.81	22.02			

Abbreviations: PT=Perspective Taking Scale, FS=Fantasy Scale, EC=Empathic Concern Scale, PD=Personal Distress Scale, VET=Volunteer Empathy Test

Table 23

Matrix of Correlation Coefficients Between VET and IRI Scales For Groups B and C

	AGE	VET	PT	FS	EC
VET	.05				
PT	.26**	.15*			
FS	-.18*	.12	.05		
EC	.13*	-.01	.27**	.27**	
PD	-.29**	-.26**	-.27**	.11	.07

* p= .05
** p= .01

Abbreviations: VET=Volunteer Empathy Test, PT=Perspective Taking Scale, FS=Fantasy Scale, EC=Empathic Concern Scale, PD=Personal Distress Scale

with the Fantasy Scale and the Personal Distress Scale of the IRI. There were positive correlations demonstrated between age and the Perspective Taking Scale as well as the Empathic Concern Scale. The Perspective Taking Scale showed a positive correlation with the Empathic Concern Scale but a negative correlation with the Personal Distress Scale. The Empathic Concern Scale also exhibited a positive correlation with the Fantasy Scale. Finally, there was a positive correlation between the VET and Perspective Taking Scale and a negative correlation between the VET and Personal Distress Scale.

Group B

Pearson correlation coefficients examining the relationships between the VET, age, and four scales of the IRI for group B were calculated and are reported in Table 24. The Fantasy Scale of the IRI and age both showed correlations with the VET. The FS Scale was positively correlated while age was negatively correlated for group B. This would suggest that subjects were better at role fantasizing as their scores on the VET increased. Results also indicated that as subjects became older, their VET score decreased. A closer examination of group means based on age groupings (16-22, 23-29, 30-39, 40-49, 50+) indicated that the age group of 50+ skewed results downward, thus creating the suggestion that VET scores and age were inversely related. The Empathic Concern Scale correlated

Table 24

Matrix of Correlation Coefficients Between

VET and IRI Scales For Group B

	AGE	VET	PT	FS	EC
VET	-.28**				
PT	.20*	-.01			
FS	-.19*	.27**	.10		
EC	.16*	-.03	.33**	.33**	
PD	-.30**	-.01	-.20*	.07	-.01

* p= .05
** p= .01

Abbreviations: VET=Volunteer Empathy Test, PT=Perspective Taking Scale, Fantasy Scale, Empathic Concern Scale, Personal Distress Scale

positively with the Fantasy Scale, Perspective Taking Scale and age. Thus, it appeared that for group B, as age increased, the subject was better able to experience what Davis (1983) expressed as "feelings of sympathy and concern for unfortunate others" (p. 113). The Personal Distress Scale correlated negatively with the Perspective Taking Scale and age. Thus it seemed as individuals grew older and/or were more capable of adopting the psychological point of view of another, their level of personal distress decreased.

Group C

Pearson correlation coefficients exploring the relationships between the VET, age, and four scales of the IRI for group C were also calculated and are reported in Table 25. A positive correlation between the Perspective Taking Scale and age was demonstrated. There were no other significant correlations, positive or negative, between any of the scales and/or the VET.

Gender Effects Versus Group Effects

Group A had demonstrated that females scored higher than males on the VET and three of the four scales of the IRI (FS, EC, and PD). Two-way ANOVAs exploring potential main effects of either groups (high or low) or gender (male or female) as well as interactions between them for the VET and scales of the IRI were not calculated.

Table 25

Matrix of Correlation Coefficients Between

VET and IRI Scales For Group C

	AGE	VET	PT	FS	EC
VET	.13				
PT	.34*	.07			
FS	-.05	.19	-.11		
EC	.07	.00	.13	.07	
PD	.03	.05	-.24	.20	.25

* p= .05
** p= .01

Abbreviations: VET=Volunteer Empathy Test, PT=Perspective Taking Scale, FS=Fantasy Scale, EC=Empathic Concern Scale, PD=Personal Distress Scale

Group C did not contain sufficient numbers of males to allow for meaningful calculation of gender differences.

Age Effects Versus Group Effects

Two way ANOVAs exploring potential main effects of either groups (high or low) or age (grouping 1, ages 18-22; grouping 2, ages 23-29; grouping 3, ages 30-39; grouping 5, ages 40-49; grouping 5; ages 50 and over) as well as interactions between them for the VET and scales of the IRI were calculated. Tables 26A, 27A, 28A, 29A and 30A report the ANOVA results while Tables 26B, 27B, 28B, 29B and 30B report specific cell means.

Findings relating to main effects as determined by the two way ANOVAs pertaining to the scales of the IRI and the VET included the following:

1. The lowest age group (ages 16 to 22) had a significantly lower score than other age groups for the Perspective Taking Scale.

2. The age group from 23 to 29 had a significantly higher score than other age groups for the Fantasy Scale.

3. There were no significant differences pertaining to ages levels but group B subjects scored significantly lower than group C subjects for the Personal Distress Scale.

4. Both the youngest (16-22) and oldest (50+) age groups scored significantly lower on the VET. In addition, group B scored significantly higher than group C.

Table 26A

Summary of Two Way ANOVA Results Between Age and High Versus Low Empathy Groups For Perspective Taking Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	38.02	2.35	.13
Age	53.29	3.29	.01
2-Way Interactions	3.68	.23	.88

Table 26B

Matrix of Cell Means For Perspective Taking Scale

	Age				
	16-22	23-29	30-39	40-49	50+
Group					
High	17.11	19.76	20.63	19.82	21.14
(N)	(19)	(29)	(27)	(22)	(14)
Low	16.22	17.70	18.75	19.50	0.00
(N)	(9)	(10)	(4)	(6)	(0)

Table 27A

Summary of Two Way ANOVA Results Between Age and High Versus Low Empathy Groups For Fantasy Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	10.45	.31	.58
Age	84.39	2.48	.05
2-Way Interactions	7.14	.21	.89

Table 27B

Matrix of Cell Means For Fantasy Scale

Group		Age 16-22	23-29	30-39	40-49	50+
	High	16.05	19.21	15.74	15.64	13.93
(N)		(19)	(29)	(27)	(22)	(14)
	Low	17.89	18.60	16.75	16.67	0.00
(N)		(9)	(10)	(4)	(6)	(0)

Table 28A

Summary of Two Way ANOVA Results Between Age and High Versus Low Empathy Groups For Empathic Concern Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	6.10	.34	.56
Age	22.09	1.23	.30
2-Way Interactions	1.99	.11	.95

Table 28B

Matrix of Cell Means For Empathic Concern Scale

	Age				
Group	16-22	23-29	30-39	40-49	50+
High	20.00	21.48	22.37	21.18	22.86
(N)	(19)	(29)	(27)	(22)	(14)
Low	21.22	22.00	22.00	21.50	0.00
(N)	(9)	(10)	(4)	(6)	(0)

Table 29A

Summary of Two Way ANOVA Results Between Age and High Versus Low Empathy Groups For Personal Distress Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	387.68	16.24	.00
Age	40.72	1.71	.15
2-Way Interactions	55.41	2.32	.08

Table 29a

Matrix of Cell Means For Personal Distress Scale

		Age				
		16-22	23-29	30-39	40-49	50+
Group						
	High	11.58	10.28	9.26	7.14	7.93
(N)		(19)	(29)	(27)	(22)	(14)
	Low	12.89	15.10	11.25	15.83	0.00
(N)		(9)	(10)	(4)	(6)	(0)

Table 30A

Summary of Two Way ANOVA Results Between Age and High Versus Low Empathy Groups For The Vet

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	44,004.97	163.59	.00
Age	1,236.80	4.60	.00
2-Way Interactions	94.45	.35	.79

Table 30B

Matrix of Cell Means For the VET

Group		Age				
		16-22	23-29	30-39	40-49	50+
	High	94.47	102.66	96.37	98.55	80.29
(N)		(19)	(29)	(27)	(22)	(14)
	Low	49.33	58.30	54.50	58.33	0.00
(N)		(9)	(10)	(4)	(6)	(0)

Education Effects Versus Group Effects

A series of two way ANOVAs exploring potential main effects of either groups (high or low) or education (group 1, grade 9 or less; group 2, grade 10-12; group 3, undergraduate degree; group 4, masters degree; group 5, doctorate) as well as interactions between them for the VET and scales of the IRI were calculated. Tables 31A, 32A, 33A, 34A and 35A report the ANOVA results while Tables 31B, 32B, 33B, 34B and 35B report specific cell means.

Findings included the following:

1. Group B scored significantly higher than group C for the Perspective Taking Scale without regard to level of education.

2. Group B scored significantly lower than group C on the Personal Distress Scale, regardless of educational level.

3. Group B scored significantly higher than group C on the VET. In addition, there was a positive relationship between level of education and VET score, although levels one and two were similar in score (grades 9 or less and 10 to 12) and significantly different from levels three to five (Bachelor, Masters and Doctoral levels).

Table 31A

Summary of Two Way ANOVA Results Between Education and High Versus Low Empathy Groups For Perspective Taking Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	70.27	4.10	.05
Education	31.13	1.82	.13
2-Way Interactions	19.73	1.15	.32

Table 31B

Matrix of Cell Means For Perspective Taking Scale

Group		Education				
		<gr 10	10-12	Bachelor	Masters	Ph.D.
	High	0.00	20.64	18.66	20.78	21.80
(N)		(0)	(11)	(58)	(37)	(5)
	Low	20.50	17.35	17.91	15.00	0.00
(N)		(2)	(17)	(11)	(1)	(0)

Table 32A

Summary of Two Way ANOVA Results Between Education and High Versus Low Empathy Groups For Fantasy Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	58.62	1.59	.21
Education	15.82	.43	.79
2-Way Interactions	5.72	.16	.86

Table 32B

Matrix of Cell Means For Fantasy Scale

		Education				
Group		<gr 10	10-12	Bachelor	Masters	Ph.D.
	High	0.00	15.00	16.52	16.84	16.00
(N)		(0)	(11)	(58)	(37)	(5)
	Low	18.50	16.53	18.27	22.00	0.00
(N)		(2)	(7)	(11)	(1)	(0)

Table 33A

Summary of Two Way ANOVA Results Between Education and High Versus Low Empathy Groups For Empathic Concern Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	0.00	0.00	.99
Education	23.39	1.33	.26
2-Way Interactions	4.87	.28	.76

Table 33B

Matrix of Cell Means For Empathic Concern Scale

	Education				
	<gr 10	10-12	Bachelor	Masters	Ph.D.
Group					
High	0.00	21.73	21.38	22.24	18.20
(N)	(0)	(11)	(58)	(37)	(5)
Low	19.50	21.94	20.91	25.00	0.00
(N)	(2)	(17)	(11)	(1)	(0)

Table 34A

Summary of Two Way ANOVA Results Between Education and High Versus Low Empathy Groups For Personal Distress Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	209.33	8.38	.00
Education	49.35	1.98	.10
2-Way Interactions	23.28	.93	.40

Table 34B

Matrix of Cell Means For Personal Distress Scale

Group		Education				
		<gr 10	10-12	Bachelor	Masters	Ph.D.
	High	0.00	10.18	10.16	7.65	10.40
(N)		(0)	(11)	(58)	(37)	(5)
	Low	13.50	15.65	12.18	12.00	0.00
(N)		(2)	(17)	(11)	(1)	(0)

Table 35A

Summary of Two Way ANOVA Results Between Education and High Versus Low Empathy Groups For The VET

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	14,168.65	71.45	.00
Education	3,089.06	15.58	.00
2-Way Interactions	824.16	4.16	.02

Table 35B

Matrix of Cell Means For The VET

Group		Education				
		<gr 10	10-12	Bachelor	Masters	Ph.D.
	High	0.00	67.00	96.81	102.43	104.80
(N)		(0)	(11)	(58)	(37)	(5)
	Low	46.00	47.06	59.18	94.00	0.00
(N)		(2)	(17)	(11)	(1)	(0)

Marital Status Effects Versus Group Effects

A series of two way ANOVAs exploring potential main effects of either groups (high or low) or marital status (group 1, single; group 2, married; group 3, living commonlaw; group 4, separated/divorced; group 5, widowed) as well as interactions between them for the VET and scales of the IRI were calculated. Tables 36A, 37A, 38A, 39A and 40A report the ANOVA results while Tables 36B, 37B, 38B, 39B and 40B report specific cell means.

These two way ANOVAs yielded the following results:

1. There were insufficient numbers of widowed subjects (1 only) to include in the two way ANOVAs.

2. Regardless of marital status, group B subjects scored significantly higher than group C subjects for the Perspective Taking Scale.

3. Married subjects scored significantly lower than all other groups for the Personal Distress Scale.

4. Regardless of marital status, group B subjects scored significantly higher than group C subjects on the VET.

Table 36A

Summary of Two Way ANOVA Results Between Marital Status and High Versus Low Empathy Groups For Perspective Taking Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	81.34	4.70	.03
Marital Status	23.28	1.34	.26
2-Way Interactions	27.98	1.62	.19

Table 36B

Matrix of Cell Means for Perspective Taking Scale

Group		Marital Status			
		Single	Married	Commonlaw	Divorced
	High	19.35	20.39	17.50	19.50
(N)		(43)	(49)	(8)	(10)
	Low	15.92	19.10	20.25	17.00
(N)		(12)	(10)	(4)	(5)

Table 37A

Summary of Two Way ANOVA Results Between Marital Status and High Versus Low Empathy Groups For Fantasy Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	21.35	.57	.45
Marital Status	14.86	.40	.75
2-Way Interactions	9.45	.25	.86

Table 37B

Matrix of Cell Means For Fantasy Scale

Group		Marital Status			
		Single	Married	Commonlaw	Divorced
	High	16.98	15.86	16.63	16.80
(N)		(43)	(49)	(8)	(10)
	Low	18.17	17.10	19.00	15.20
(N)		(12)	(10)	(4)	(5)

Table 38A

Summary of Two Way ANOVA Results Between Marital Status and High Versus Low Empathy Groups For Empathic Concern Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	0.00	.00	.99
Marital Status	5.94	.32	.81
2-Way Interactions	2.11	.12	.95

Table 38B

Matrix of Cell Means For Empathic Concern Scale

		Marital Status			
		Single	Married	Commonlaw	Divorced
Group					
(N)	High	21.26	21.78	20.88	22.40
		(43)	(49)	(8)	(10)
(N)	Low	21.25	22.20	21.00	21.20
		(12)	(10)	(4)	(5)

Table 39A

Summary of Two Way ANOVA Results Between Marital Status and High Versus Low Empathy Groups For Personal Distress Scale

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	486.62	20.34	.00
Marital Status	70.06	2.93	.04
2-Way Interactions	36.94	1.54	.21

Table 39B

Matrix of Cell Means For Personal Distress Scale

	Marital Status			
Group	Single	Married	Commonlaw	Divorced
High	11.16	8.00	10.13	8.30
(N)	(43)	(49)	(8)	(10)
Low	13.92	13.00	13.50	17.60
(N)	(12)	(10)	(4)	(5)

Table 40A

Summary of Two Way ANOVA Results Between Marital Status and High Versus Low Empathy Groups For The VET

Source of Variation	MS	F	Sig of F
Main Effects			
High/Low Group	45638.09	156.76	.00
Marital Status	398.26	1.37	.26
2-Way Interactions	198.11	.68	.57

Table 40B

Matrix of Cell Means For The VET

Group		Marital Status			
		Single	Married	Commonlaw	Divorced
	High	95.35	95.47	97.75	101.80
(N)		(43)	(49)	(8)	(10)
	Low	50.08	53.20	43.00	66.40
(N)		(12)	(10)	(4)	(5)

Two Way ANOVAs Summary

An overview of findings from two way ANOVAs suggested several main effects. Main effects of group B versus group C were noted for the Perspective Taking Scale, Personal Distress Scale, and VET. Main effects of age were demonstrated for the Fantasy Scale and the VET. Education main effects were found for the VET. Main effects of marital status were noted for the Personal Distress Scale.

Test-Retest Reliability

Test-retest reliability for the VET and IRI were calculated based on data gathered from 27 subjects belonging to either group B and C. Subjects completed the VET and IRI on a second administration approximately three to four weeks after the first administration. Table 41 reports reliability coefficients. It is noteworthy that the test-retest reliability coefficient for the VET is high at .98.

Table 41

Test-Retest Reliability Coefficients

For VET and IRI (Groups B and C)

Scale (# subj.)	Reliability Coefficient
VET (27)	.98
PT (27)	.80
FS (27)	.85
EC (27)	.86
PD (27)	.82

CHAPTER V

DISCUSSION AND IMPLICATIONS

Discussion

General Comments

In any research of this nature, cooperation from a large number of organizations and individuals is required. This cooperation was evidenced throughout this study as hospitals, counseling agencies, school systems, university faculties and many individuals contributed their time and energies towards providing the information that was necessary for completing this research.

Also in any research of this nature, despite considerable cooperation, difficulties with data collection arise. In establishing item to total reliability for each of the original 75 items of the VET, a large sample of university students in several classes were administered the questionnaire. The researcher had access to university students within the Education and Nursing faculties of the University of Alberta. A potential difficulty caused by use of this population related to the lack of randomly selected subjects. A second difficulty related to the potential for subjects who were "low empathic" to refuse to participate in the study. Subjects were given the option of

exclusion from the study and early dismissal from regular class time. This again tended to skew results because of a lack of randomly chosen subjects. To reduce the likelihood of a homogenous group, the sample size was large.

Samples used for the high and low empathic groups were somewhat more difficult to obtain. High empathic subjects were chosen from several professions and this involved contacting many individuals employed in a wide array of settings. An assumption made by the researcher was that for this group of subjects, allowing prospective participants the choice as to whether or not they participated in the study, in reality, allowed for self selection to occur regarding the subjects' level of empathy. Those individuals who did not feel highly motivated to complete the testing were encouraged to decline involvement as it seemed likely that they would be less empathic than their peers. It was believed that this self selection increased the chances of the remaining individuals falling in the high empathic category.

The low empathic individuals proved to be very difficult to recruit. By their very nature they were not inclined to "help" someone by completing a questionnaire, especially twice. In addition, it was assumed that no one would willingly step forward and be identified as "low empathic." Unsuccessful efforts to access a prison population were followed by access to a sample consisting of store clerks who were employed by a firm which offered little to their employees in the way of benefits, paid

minimum wage, and employed individuals who were limited in their education and generally had few skills. The employer would not release employees for testing during a single sitting. This meant that several small groups of individuals in retail stores throughout the greater Edmonton area had to be personally canvassed. As well, three supervisors were also asked to complete the measure as examples for others. While test scores did affirm statistical differences between the high empathic sample and individuals from the store clerk sample, there remains some concerns regarding the significant differences between the make up of the two groups. As an example, the store clerks sample consisted of females with the exception of the three male supervisors. The high empathic group contained a more even distribution of males and females. This raises questions about whether the statistical differences between the two groups were as a result of their level of empathy or whether it was because of other differences such as sex, age or level of education.

In completing this study, the researcher experienced many personal insights. This existential voyage in many ways complimented the statistical nature of this research. The researcher did not have any previous experience with palliative care prior to completion of this study. As the study progressed, the "mechanics" of test construction were frequently tempered by the reality associated with a terminally ill patient. During the time span of this research, an individual known to the researcher

was diagnosed as terminally ill, was admitted to a palliative care unit, and then passed away just shortly before this research was completed. For the researcher, this experience helped to further establish the value of a screening device which could assist in the selection of volunteers.

Findings

Data analysis of the VET provided information regarding reliability. Statistical analysis supported the internal consistency of the VET and indicated that the 24 items each contributed positively to the overall reliability of the test. In addition, test-retest information indicated that results across time were likely consistent. The VET could be expected to provide findings which were not influenced by time or internal test difficulties.

Validation of the usefulness of information provided by the VET was also suggested. Analysis of individual questions by experts, comparison of the VET to scales of the IRI, and use of contrasting groups (high and low empathic) indicated that the VET was potentially useful as a screening device to differentiate levels of communicated empathy in subjects.

Comparison of the VET to IRI scales indicated that two of the four IRI scales had some correlation with the VET. High scorers on the VET were likely to be low scorers on the Personal Distress Scale. This was logical in that individuals who were

self assured, confident and less likely to become distressed by a patient's circumstances would communicate empathy more easily. Individuals who were personally distressed would have more difficulty appreciating a patient's circumstances and communicating empathy to them. In addition, there was a weak suggestion that individuals scoring high on the VET were also likely to have an elevated score on the Perspective Taking Scale of the IRI. This seemed to suggest that the VET was in some way measuring the subject's ability to "see" things as the patient did. This seemed logical in that communicating empathy logically involved a component of "walking in a patient's shoes."

The fact that there was no demonstrated correlation between the VET and two of the four IRI scales, as well as the limited correlations with the other two IRI scales suggested two points. First, despite the IRI representing one of the most recently substantiated measures of empathy constructs, there was no clear evidence that it measured communicated empathy, as defined in this study. If empathy consists of several constructs, then this research indicated that a measure specific to communicated empathy was required and unique from the IRI. Secondly, evidence from this research suggested that a situation specific measure unique to palliative care potentially assessed something which a more general empathy measure did not. This supports the contention that more situation specific measures for unique settings are required. The concept of a generic form of empathy

was challenged by this research.

Effects of gender, age, education and marital status on VET results were analyzed using a series of two way ANOVAs. These ANOVAs explored main effects and interactions.

Gender effects could not be explored as the membership of low empathic group did not contain sufficient numbers of male subjects. An analysis of the 75 item VET did suggest that females were slightly more empathic than males. As noted earlier, the empathy literature has generally been mixed regarding gender effects.

Age effects were demonstrated and a non-linear relationship was suggested. Results indicated that for age, the youngest and oldest age groups (under 22 and over 50 years of age) obtained the lowest scores on the VET. From a developmental perspective, this seemed logical in that the youngest subjects were still focusing on their own identity and would, therefore, experience problems in empathizing with other. It was also suggested that the younger subjects in the study had limited experiences with the terminally ill and/or with death. The older age group scored low on the VET for perhaps different reasons. It was suggested that this age tended to be advice orientated and tended to engage in low empathic, "wise counsel," rather that "listening" to the patient. Whether this would also suggest that training this age group would be difficult requires further study.

Effects of education were demonstrated on the VET. Subjects

having grade 12 or less scored significantly lower than those with a Bachelor degree or higher. Whether this reflected a difference of intellect or the ability of better educated individuals to communicate empathy remains supposition. There was potentially a suggestion that this finding supported the view that communicated empathy was a skill which could be taught.

Marital status did not demonstrate any relationship with the VET. It would have been useful to have had more widowed subjects participate in the study to determine whether the death of a spouse (potentially through a terminal illness) impacted one's ability to communicate empathy. The selection of volunteers in many palliative care units precluded individuals who had experienced the loss of a spouse through a terminal illness. This suggests a working assumption that learning through experience may negatively impact on one's ability to communicate empathy.

Limitations

Messick (1989) refers to validity as,

> An integrated evaluative judgement of the degree to which empirical evidence and theoretical rationales support the adequacy and appropriateness of inferences and actions based on test scores or other modes of assessment. (p. 13)

Thus validation for any new test instrument needs to be viewed as a process rather than an event. Initial steps in this process

were completed. Statistical support pertaining to internal consistency reliability, test-retest reliability and construct validity were demonstrated. A relationship between two of the scales of the IRI (Perspective Taking and Personal Distress Scales) and the VET were suggested. Educational and age influences within the VET, as well as expert support for the VET were also suggested. All began to contribute towards the valid use of the VET as a measure of communicated empathy. Limitations of these findings must be emphasized however.

A need to increase the sample size of the low empathic group (especially the males) and demonstration of the VET's ability to predict who would either benefit from training, or be able to function as a contributing volunteer in a palliative care setting, must yet be undertaken.

More exploration of the relationship between education and the VET must be completed. The potential for the VET to be a test of intellectual capabilities must be evaluated.

Statistical limitations related to the method used to analyze data must be mentioned. The repeated use of t-test analysis combined with an overdependence on one external criteria (IRI) weakened findings generally. Factor analysis, use of multiple regression, and the inclusion of other external criteria would have added important information about the VET. Further concerns regarding unwanted method variance caused by an

overreliance on comparisons with a similar paper-and-pencil test (IRI) should be noted.

Implications For Further Research and Use

The Volunteer Empathy Test requires continued validation in terms of whether it assesses what it is intended to and the degree to which it does this. The instrument was originally developed to assist volunteer coordinators in hospital settings (with an emphasis on palliative care) screen prospective volunteers to enable the coordinators to choose those applicants who would likely succeed in training.

While further research will continue to provide important information regarding the reliability and validity of the VET, pragmatically it is suggested that inclusion of this measure with usual screening practices for potential volunteers in palliative care facilities is appropriate. The Volunteer Empathy Test appears to have usefulness in the identification of those individuals who may benefit from training and will act as an adjunct to current practices in screening potential volunteers. However, it must be remembered that the VET is a discrimination tool useful only in the sense that it adds to an evaluator's ability to compare individual's scores. It is still the evaluator's responsibility to establish which scores are "low" and which are "high" for their particular circumstance. The use of the VET by itself as a screening tool is not yet fully corroborated by research findings.

Further research and validation of the VET is required to allow for its widespread clinical use, particularly as a lone test instrument. Comparison of contrasting groups that are matched for levels of education and gender would be an important source of further data regarding the VET. Obtaining information regarding convergent validity through the use of behavioral measures of respondents would also be useful. External validation, referring to the substantiation of the VET with other measures, its predictive correlates, and its comparisons across various settings and groups must still be completed. As an example, a study could investigate the relationship between VET scores and the likelihood of potential palliative care volunteers successfully completing training or hospital-based volunteerism. Another research direction or alternative could examine relationships between psychological profiles of proven or "successful" palliative care volunteers and their VET scores. Perhaps the ultimate test of validity must include direct patient involvement of analysis of the VET and its screening ability. Careful adherence to ethical guidelines to ensure respect of patient rights must be assured.

This study also provided some suggestion that research pertaining to the teaching of setting specific communicated empathy with such groups as nursing students may be of value.

Cronbach (1984) states that validation is a "...lengthy-indeed, endless-process of revising hypotheses..." that is "...a

matter of asking tough questions about the test content and its correlates. For such a free-ranging program of analysis there is no simple or ideal design" (p. 134).

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APPENDIX A

IRI Scales and 75 Item Volunteer Empathy Test

Survey of Communication Styles

Thank you for participating in this study of communication styles. The survey has 2 parts. Part 1, questions 1 to 28 inclusive, contains a series of statements for which you are to rate how closely they describe you. Part 2, questions 29 to 103, contains a series of statements to which you are to choose the option closest to the response you would give in that situation.

There are no correct answers to **ANY** of the questions. Please note that **ALL** responses you provide will be held in strictest confidence. The identification number on your questionnaire is for the purpose of data analysis only. **NO** responses will be identified or presented at the individual level. Results will only be used at the group level (such as by age, gender, or educational level).

In order to analyze the responses in a meaningful way, **we need the following instructions to be carefully followed:**

On your scoring sheet, **first**, fill in the circle indicating your gender (**M**ale or **F**emale). **Second**, under the section titled "Grade or Educ", fill in the current year of program in which you are enrolled. **Third**, complete the section titled, "Birth Date", being careful to follow the section headings. **Fourth**, <u>in box K</u>,

fill in number 1 if you are single
fill in number 2 if you are married
fill in number 3 if you are living commonlaw
fill in number 4 if you are separated/divorced
fill in number 5 if you are widowed

Now you may proceed with completion of the actual questions, beginning with question one on the next page.

If you are interested in the group results of this survey, have any further questions, or wish to share your reaction to the study, please contact:

Jim Canniff
Chartered Psychologist
11503 - 124 Street
453 - 1873

<u>**PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED**</u>. Thank you for your time and cooperation.

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBES ME VERY WELL				DESCRIBES ME WELL

ITEM

1. I daydream and fantasize, with some regularity, about things that might happen to me.

2. I often have tender, concerned feelings for people less fortunate than me.

3. I sometimes find it difficult to see things from the "other guy's" point of view.

4. Sometimes I don't feel very sorry for other people when they are having problems.

5. I really get involved with the feelings of the characters in a novel.

6. In emergency situations, I feel apprehensive and ill-at-ease.

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

8. I try to look at everybody's side of a disagreement before I make a decision.

9. When I see someone being taken advantage of, I feel kind of protective towards them.

10. I sometimes feel helpless when I am in the middle of a very emotional situation.

11. I sometimes try to understand my friends better by imagining how things look from their perspective.

12. Becoming extremely involved in a good book or movie is somewhat rare for me.

13. When I see someone get hurt, I tend to remain calm.

14. Other people's misfortunes do not usually disturb me a great deal.

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

16. After seeing a play or movie, I have felt as though I were one of the characters.

17. Being in tense emotional situation scares me.

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

19. I am usually pretty effective in dealing with emergencies.

20. I am often quite touched by things that I see happen.

21. I believe that there are two sides to every question and try to look at them both.

22. I would describe myself as a pretty soft-hearted person.

23. When I watch a good movie, I can very easily put myself in the place of a leading character.

24. I tend to lose control during emergencies.

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

27. When I see someone who badly needs help in an emergency, I go to pieces.

28. Before criticizing somebody, I try to imagine how I would feel it I were in their place.

DIRECTIONS: Please assume someone in the last days of his/her life is addressing the following statements or questions to you. Please choose the response which most closely approximates what you would want to say in return. **Indicate your choice for each question by filling in the correct letter on the supplied answer sheet. Remember that only one choice per question may be made and complete every item.**

29. **Am I dying?**

a) It would probably help if you think about something else.
b) You want to know if you're dying?
c) You probably have a lot of feelings about dying.

30. **My son used to visit me often. Now he hardly ever comes.**

a) Your son has not been visiting lately?
b) You're fairly lonely right now, aren't you?
c) He probably wants to come more often but is just too busy.

31. **I'm not sure about these medications. They're giving me pills for the pain but I don't think they are the right ones. They don't seem to be working.**

a) You're worried about the pain?
b) Maybe you just need to give them more time to take effect.
c) You seem to be wondering if you are on the right medications or not.

32. **I can have a weekend pass if I want one. It's so much work for everyone at home.**

a) Sometimes you feel like you are a burden to your family.
b) It's hard to go on a weekend pass when it's so much work for everyone at home.
c) They won't mind, they love you and want you to be with them.

33. **The physiotherapist is always wanting me to walk but I'm so tired. The dietitian is always wanting me to eat.**

a) You need food and exercise to keep up your strength. They are probably just trying to help.
b) You're tired of people expecting so much of you.
c) The physiotherapist and dietitian keep wanting a lot from you.

34. **This is my wife's third operation! How much can she take! When do they say that's enough?**

    a) This is her third operation. You're wondering when they are going to stop.
    b) Perhaps this operation will make a difference.
    c) It's painful for you to watch you wife suffer.

35. **I'm home aren't I? Is the garden growing? Why are the walls yellow in my bedroom? (Patient is still in hospital)**

    a) My house has yellow walls too.
    b) Sometimes things are confusing.
    c) Tell me more about your home. What is it like?

36. **I don't seem to remember things like I used to. Sometimes I can't remember what I'm supposed to do next.**

    a) Sometimes it's hard to remember all the things you are supposed to do.
    b) If you concentrate on one thing at a time that might help.
    c) Between feeling sick and being tired you can feel confused about what you are supposed to remember.

37. **This home care nurse was here this morning. She talked to me about dying at home. But what about the pain?**

    a) You have fears about the pain if you go home.
    b) You talked about going home to die?
    c) Maybe it would be more comforting to you to stay in the hospital.

38. **Two weeks before my wife died, my son's marriage broke up. He's so shaken up I don't know what to say to him.**

    a) Be patient and pray. Perhaps God has an answer for both of you in your hour of need.
    b) You sound like you want to say something to him but you can't find the right words.
    c) You've lost someone special too. You know how badly your son feels and you're afraid of hurting him more.

39. **I just want to die. Why can't they leave me alone?**

    a) You feel ready. You wonder why others are so reluctant to let it happen.
    b) Everyone's just trying to help. Things really could be a lot worse.
    c) You just want it to be over and everybody to go away.

40. **I don't like it here. I want to leave. Will you take me home?**

a) You'd like to leave?
b) You have strong feelings about being here.
c) I'd really like to but I'm afraid I can't, besides the nurses are nice here.

41. **Get out of my room! I don't want you here!**

a) O.K. I'll go.
b) I was hoping to cheer you up....Can I stay for just a minute or two?
c) Yes, I'll leave. Obviously you're feeling angry.

42. **I know I'm not perfect but I've tried to lead a decent life. Why is God punishing me this way?**

a) When we look back at our life, we all have some things we feel guilty about.
b) You have led a decent life and yet you still feel punished by God.
c) He's not really punishing you. Perhaps he is testing your love for him. Be patient and faithful for a bit longer.

43. **We want to try and get to Winnipeg one more time. I have five grandchildren there you know.**

a) Have your grandchildren been in Winnipeg long?
b) It would be special for you to get to Winnipeg one more time to see your five grandchildren.
c) The problem with that is your special medical needs. I'm not sure it can be arranged. It would be expensive too.

44. **Dying is not the worst thing that can happen. I'm not pleased at the timing but I've done a tremendous amount of growing since I got ill.**

a) You've been a help to others on the unit. I could have used that kind of help when my husband died.
b) You've done a lot of growing since the illness.
c) You're satisfied with the way you have come to grips with facing your death.

45. **I can't do anything any more. I can't read, I can't drive, I can hardly dress myself.**

a) It's hard to feel helpless.
b) Are there other things you should be thankful for?
c) There's lots of things you feel you can't do right now.

46. **I hate going out in public. I never know what to say. Some friends avoid me. Others don't know what to say.**

a) You feel awkward when you go out on a visit or a pass.
b) It's hard for you to deal with your friends, isn't it?
c) Just pray for guidance, hold your head up high and do what feels best.

47. **It's my life. If I decide I want out that's my right. And certainly with this medication that will be easy enough.**

a) You need to feel in charge of your own life.
b) You have been thinking about ending your life with all this medication.
c) You know no one wants you to hurt yourself and the medication is there only to ease your pain..

48. **I don't want to see any more doctors, take any more chemo or have any more tests! But John (my husband) just keeps insisting.**

a) Maybe John is just trying to help. He is your husband.
b) It's hard to tell your husband how you really feel and what you really want.
c) John keeps on insisting you follow your doctor's orders even though you don't want to.

49. **I can sleep in the daytime but I just can't sleep at night. If I drift off, I wake up with a start and my heart is pounding.**

a) Sleeping at night is harder than during the day when people are around.
b) Perhaps you should speak to your doctor about this. He may be able to help.
c) You're worried about sleeping at night in case you don't wake up, aren't you?

50. **I'm alright but you should talk to Susan (my wife).**

a) You want me to talk to Susan?
b) You're worried about how Susan is feeling?
c) Does Susan believe in a higher power?

51. **I wanted to live long enough to see my children grow up. Why! Why! Why!**

a) Maybe God is sparing you some grief later.
b) You feel cheated because you want to see your children when they are grown up.
c) You feel very angry that you have to die before you want to.

52. **I'm going to beat this. There are exceptions to everything. I'm going to be the exception to the rule.**

a) You're hoping there still is a way to beat death.
b) Who knows. Maybe you are right. Stranger things have happened.
c) You're going to find the way to beat this.

53. **Do you know what it is like to be sick when you don't know anyone in a city? My husband died just after we moved here. It was me that was sick, not him.**

a) You want someone to come and visit you, don't you?
b) There is no one here to visit you now that your husband is dead.
c) It must be lonely for you.

54. **I used to believe in God. I don't know now.**

a) You're questioning your faith at this point in your life.
b) Modern medicine has more miracles nowadays.
c) You're not sure about God any more.

55. **My brother is looking into taking me to Mexico. I don't know why they don't use those special treatments here. It will cost so much.**

a) You wish the treatments were available here because it would be cheaper.
b) You're not sure if the Mexico trip is really the right thing to do.
c) My brother once heard of a faith healer in Toronto.

56. **They don't say how I'm doing. Nobody tells me how I'm really doing.**

a) I'll bet if you asked them they would.
b) You don't know how your health is.
c) You're concerned they might not be being straight with you.

57. **My little girl cries as soon as Bob brings her into my room. She looks to him to do everything for her now.**

a) It's hard to see her turn to her dad for everything.
b) It's probably his way of comforting her.
c) Bob does everything for her right now.

58. **Do you know what palliative means--what it really means? It means they have given up on you.**

a) You think that they have given up on you.
b) You feel like no one cares.
c) Palliative means the goal isn't to cure.

59. **I've had a good life. I was citizen of the year once and we've travelled all over the world together. We've done everything together.**

a) Things have gone well for you. You've done a lot together.
b) You're worried or sad about making this last journey alone.
c) Perhaps while you still have time you can do something else special.

60. **He puts me down all the time. He always has. Why can't he be nice? Why does he have to drink too much when he knows I'm dying?**

a) It sounds like he has a drinking problem.
b) He puts you down in lots of ways, especially by drinking.
c) It's hard to accept he isn't going to change even under these circumstances.

61. **I know doctors know best, but I feel like I have a lot of pain. Shouldn't there be a medication that would help me?**

a) You're afraid that the pain will get worse and that your view of it won't count.
b) Are you thinking that you need another doctor?
c) You're wondering if there is another medication which could ease the pain.

62. **Why do I always get this soft food? I'm not a baby you know.**

a) It's probably easier to digest.
b) You feel like a baby when they serve you strained foods.
c) It's hard to accept limits in so many areas of your life.

63. **Sometimes things around me seem really strange. Yesterday I thought the pictures were moving and my bed seemed to be floating. Is my brain quitting?**

a) It's upsetting to have strange experiences.
b) No, no. You were probably over-tired. Sometimes my eyes get blurry too.
c) Yesterday you had some strange experiences which made it seem like your brain had quit.

64. **I want to stay here every night with Susan (wife) but I don't know what to do about the kids. She needs me and so do they.**

a) You can't decide between staying with Susan or being at home with the kids.
b) You feel caught in a dilemma....neither choice makes you feel like you're doing the right thing.
c) Don't forget to take care of <u>your</u> needs too.

65. **I suppose I should make up a will before I die. It seems so final.**

a) Completing a will seems like the end.
b) If you make up a will you feel like you will die soon.
c) Wills are a wise move for anyone.

66. **Will you pray with me?**

a) I can but I won't know what to say.
b) If you'd like.
c) Let's pray together.

67. **The patient you are visiting says nothing.**

a) Stay and say nothing.
b) Leave.
c) Stay and make some "light" conversation.

68. **Even if I knew the exact time it would help. It's so hard not knowing. I want to be prepared.**

a) It's probably better that you don't know, in the long run.
b) You wish you knew the exact time you were going to die.
c) It's hard not to worry, and to feel like everything is organized for when you're gone.

69. **My children asked me what to do about the funeral. I was pleased because I thought no one would ask me what I wanted.**

a) Being respected and having some control is important for you.
b) It seems rather morbid to talk about your funeral.
c) You were pleased your children asked you what you wanted for your funeral.

70. **I've thought about leaving the hospital and never coming back. Just disappearing. No one would notice and it might be a lot faster.**

a) You've thought about just packing it all in and leaving.
b) Sometimes you'd like to take more control of your own life, including your time for death.
c) You wouldn't do that because so many people would be upset and then you would feel guilty.

71. **I don't have anything left. I've sold everything; my clothes, my furniture, my bed. Even my relatives are gone.**

a) Everything is gone....there's nothing left.
b) You feel ready now.
c) The staff and I will always visit you.

72. **I keep getting these new pains. I think maybe it will mean another operation. I hate surgery.**

a) But what if the surgery would stop the pain? Surely then it's worth it.
b) Surgery and operations are not what you want right now.
c) You really hope you won't have to have any more surgery.

73. **I keep thinking that with each day that passes, maybe things will get better. Who knows, maybe someone will discover a cure for cancer.**

a) Hope and remaining positive is important for you.
b) Modern medicine can only go so far I'm afraid.
c) Maybe if you hold on long enough, someone will find a cure.

74. **It seems like everyday the pain gets a little worse. I ask for more medication. They give it. What's going to happen when the medication won't work any more?**

a) The thought of the pain getting worse is frightening for you.
b) You're wondering if the medication will stop working at some point.
c) Think positively, it's always helped so far.

75. **Death seems so final. I've spent all of my life being so alive. It seems ironic to now die being so lifeless.**

a) Yes, but remember the joy you have brought to others. That's the person they will remember.
b) As you think about your own death, it's hard to imagine just fading away. It's not like you.
c) Cancer makes you feel so lifeless as time passes.

76. **Damn my children! I took care of them, now why can't they take care of me? They come up here to visit and all they want is for me to keep taking care of them.**

a) It's upsetting that they still seem helpless.
b) At least you can be glad that they come to visit you.
c) You're angry that they won't take care of you for a change.

77. **All I want to do is die with dignity. If it could happen while I was sleeping that would be best.**

a) Your husband and your children couldn't say good-bye then.
b) Dying in your sleep would allow you to die with dignity.
c) You're a proud person and worry that you may not die that way.

78. **I wonder what would happen if I told the nurses when to sponge bath me, if I told the doctors when to visit me, if I told the priest when to pray for me?**

a) You sound like you need to have some control in your life.
b) Staff have busy schedules to keep and try their best to please.
c) You'd like to tell the nurses, doctors and priests what to do.

79. **I want to watch from my bedroom window the children walk to school in the morning. I want to cook toast in my toaster and eat with my knife and fork. When I die, let it be at home.**

a) The hospital isn't the same as home no matter how hard staff try.
b) Dying at home, where you belong, is very important to you.
c) They will let you bring some of you personal possessions to the hospital, if you want.

80. **My husband thinks I should change doctors. He says I shouldn't be in so much pain. I don't know what to do. I like my doctor.**

a) Your husband takes good care of you doesn't he?
b) Your husband thinks your doctor might not be doing his best for you.
c) You love your husband but trust your doctor.

81. **I'm not a Christian. I don't know what will happen to my soul after I die. I don't know how to become one now.**

a) You're wondering what will happen to you after your death.
b) I wouldn't worry about that for now. Take care of your health and He will take care of you.
c) You're not sure of how to become a Christian.

82. **Sometimes at night I go into my bathroom and run the water so no one will hear me crying.**

a) When you feel like crying, you do it so no one will know.
b) Some things are so private, you feel you can't share them with anyone.
c) When you feel like crying, buzz for a nurse or a volunteer and they will cheer you up.

83. **My views on death have changed a lot. I used to not think about it. Now I wonder about it all the time.**

a) Now you think about death a lot.
b) Death is more real for you now and so you have different feelings about it.
c) I try to not spend much time thinking about death. We're all going to die in the end.

84. **I haven't told my children yet. I'm hoping Karl (husband) will. I know I don't have much time to go.**

a) Maybe you should. They will want to prepare for your death too.
b) You want your husband to tell the children that the time is near.
c) It will be hard for you to say good-bye to your children.

85. **I want to get through Christmas. I don't care what else happens but I don't want to spoil this Christmas.**

a) You'd feel guilty if your death came during the Christmas celebration.
b) Your family would understand.
c) You don't want anything to happen at Christmas.

86. **I want to be able to decide what happens to me all the way along. I want to make choices and not have them made for me.**

a) You must keep in mind that hospital staff are there for your benefit.
b) You want to make decisions for yourself.
c) It's your life and you want to run it!

87. **If I stay in the hospital then I know if something happens the staff will be there to take care of it.**

a) It's nice to have some security when you need it.
b) You need to learn not to be quite so dependent in the hospital. You can still do many things by yourself if you try.
c) The hospital staff can take care of any emergencies.

88. **I hate carrying this medical pack around. I feel like a freak. Maybe another kind of medicine would work just as well. I prefer shots to this.**

a) You wish there was another way of receiving your medicine.
b) It's hard to face all the limitations of being in a palliative care unit. Dependency is a part of it.
c) You can always check with the nursing staff to see if you can change the way you receive your medication.

89. **I go to church every Sunday. I read the Bible. "Keep the faith" they say, believe in miracles..., but what hope is there really?**

a) You should speak with our minister who visits regularly. I'm sure he could help.
b) How can you believe in God when there isn't any hope?
c) Your faith in God is in doubt because you are terminally ill and it doesn't seem fair.

90. **I'm not a brave person. I've learned how to turn off the pain though. In fact, I'm rather proud of myself.**

a) You feel pleased and proud that you have learned how to treat one part of your illness--the pain.
b) Are there other aspects of your cancer you worry about?
c) You're feeling proud of yourself.

91. **I'm not ready for this. If I had any idea this was coming, I would have done so many things differently.**

a) You weren't ready for this. You have more to do.
b) You feel cheated by your illness. It has raised questions about how you have lived your life.
c) One of the problems we all face is the unpredictability of life.

92. **Why do they look so guilty when they come to visit? I'm the one letting them down.**

a) You're doing the best you can, considering the circumstances. Being hard on yourself won't help.
b) You feel like you're letting them down.
c) You see yourself as failing, not them.

93. **I still have the opportunity to do some things on the passes I have. I can't do much but I plan to use my time well.**

a) There's some time left on passes to do some things.
b) You want to focus on how you are living not on how you are dying.
c) You have to keep in mind your limitations. Don't try to do too much.

94. **I'm going to bring some of my possessions to the hospital. I want some of my foods too.**

a) You want to be as comfortable as possible.
b) You know how rotten hospital food can be!
c) You're going to bring some personal items from home.

95. **If I can get my husband to do it, I'd like to try and go home for the last few weeks.**

a) Dying at home will feel better for you.
b) I'm sure it can be arranged but you medications will need to be organized and you'll need a nurse.
c) If your husband will help, you'll go home for your last few weeks.

96. **Sometimes I feel more like a guinea pig with all these pain killers. Isn't there a right one for me?**

a) With all the pain killers they try, you feel more like a guinea pig at times.
b) It would be nice if your medication could be simpler and more routine.
c) You should consider yourself lucky that there are so many choices for you.

97. **I know everyone cares for me here, but secretly I pray for "you know what" to happen.**

a) Can you explain what you mean? It will help you to talk about it.
b) You're praying that death will come quickly.
c) You don't want to die slowly. You'll feel happier if it happens quickly.

98. **Why does it always hurt? All this medication seems to do is make me drowsy. Maybe they think if I look stupid it doesn't hurt.**

a) Sometimes no one can understand how much it really hurts.
b) No one thinks you look stupid so don't worry.
c) The medication makes you drowsy but it doesn't always take away the pain.

99. **Death seems so unfair. I don't smoke, I don't drink. I know lots of people who do both and they'll probably live to see 100!**

a) Others should be sicker than you, right?
b) You're saying to yourself, "Why me, I don't deserve this. Others have taken worse care of themselves."
c) Life isn't fair but you've had a good life, haven't you?

100. **It's sad. I'm just now appreciating the importance of my friendships that I've had and will soon lose.**

a) Try thinking about the good times that you have had with your friends.
b) You're thinking about what your are going to lose soon.
c) You're feeling sad about the friendships you've had and not appreciated until now.

101. **I've got to visit with mother again. She's in a nursing home. It's so important to me. I want to tell her how much I love her.**

a) It will be nice to leave the hospital for awhile.
b) You really want to see your mother again.
c) You need to say good-bye to your mother.

102. **I hate to complain; I feel very lucky to be here. I do have some gripes though.**

a) You wish you could complain but your head says you should feel happy just to be receiving care in the palliative care unit.
b) You don't really have anything important to complain about.
c) You're not one to complain because they didn't have to take you in tne unit.

103. **If I go home for a visit, I feel like I spoil everyone else's weekend so I can enjoy mine. I suppose I shouldn't go.**

a) Staying at the hospital won't bother anyone else.
b) You really want to be at home without being a bother.
c) Nonsense! I'm sure they will be glad to have you.

APPENDIX B

IRI and 24 Item Volunteer Empathy Test

Survey of Communication Styles

Thank you for participating in this study of communication styles. The survey has 2 parts. Part 1, questions 1 to 28 inclusive, contains a series of statements for which you are to rate how closely they describe you. Part 2, questions 29 to 58, contains a series of statements to which you are to choose the option closest to the response you would give in that situation.

There are no correct answers to **ANY** of the questions. Please note that **ALL** responses you provide will be held in strictest confidence. The identification number on your questionnaire is for the purpose of data analysis only. **NO** responses will be identified or presented at the individual level. Results will only be used at the group level (such as by age, gender, or educational level).

In order to analyze the responses in a meaningful way, **WE NEED THE FOLLOWING INSTRUCTIONS TO BE CAREFULLY FOLLOWED**:

On your scoring sheet, **first**, fill in the circle indicating your gender (**Male** or **Female**).

Second, under the section titled "Grade or Educ", fill in **1** if you completed grade **9 or less**, fill in **2** if you completed grade **10, 11, or 12**, fill in **3** if you have completed **part or all of a college or university degree**, fill in **4** if you have completed **part or all of a masters degree**, or fill in **5** if you have completed **part or all of a doctorate**.

Third, fill in today's date under the section titled "Birth Date".

Fourth, **in box K**, fill in number **1** if you are **single**, fill in number **2** if you are **married**, fill in number **3** if you are **living commonlaw**, fill in number **4** if you are **separated/divorced**, fill in number **5** if you are **widowed**.

Fifth, **in boxes L&M**, fill in your **age**.

Sixth, **in box N**, fill in **1** if you are a **psychologist**, fill in **2** if you are an **inmate**, fill in **3** if you are a **educational psychology student**, fill in **4** if you are a **school counselor**, fill in **5** if you are a **nursing student**, fill in **6** if you are a **hospital volunteer or nurse**, or fill in **7** if you are **anything else**.

Now you may proceed with completion of the actual questions, beginning with question one on the next page.

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME VERY WELL				DESCRIBES ME WELL

ITEM

1. I daydream and fantasize, with some regularity, about things that might happen to me.

2. I often have tender, concerned feelings for people less fortunate than me.

3. I sometimes find it difficult to see things from the "other guy's" point of view.

4. Sometimes I don't feel very sorry for other people when they are having problems.

5. I really get involved with the feelings of the characters in a novel.

6. In emergency situations, I feel apprehensive and ill-at-ease.

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

8. I try to look at everybody's side of a disagreement before I make a decision.

9. When I see someone being taken advantage of, I feel kind of protective towards them.

10. I sometimes feel helpless when I am in the middle of a very emotional situation.

11. I sometimes try to understand my friends better by imagining how things look from their perspective.

12. Becoming extremely involved in a good book or movie is somewhat rare for me.

13. When I see someone get hurt, I tend to remain calm.

14. Other people's misfortunes do not usually disturb me a great deal.

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

16. After seeing a play or movie, I have felt as though I were one of the characters.

17. Being in tense emotional situation scares me.

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

19. I am usually pretty effective in dealing with emergencies.

20. I am often quite touched by things that I see happen.

21. I believe that there are two sides to every question and try to look at them both.

22. I would describe myself as a pretty soft-hearted person.

23. When I watch a good movie, I can very easily put myself in the place of a leading character.

24. I tend to lose control during emergencies.

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

27. When I see someone who badly needs help in an emergency, I go to pieces.

28. Before criticizing somebody, I try to imagine how I would feel it I were in their place.

DIRECTIONS: Please assume someone in the last days of his/her life is addressing the following statements or questions to you. Please choose the response which most closely approximates what you would want to say in return. **Indicate your choice for each question by filling in the correct letter on the supplied answer sheet. Remember that only one choice per question may be made and complete every item.**

29. **My son used to visit me often. Now he hardly ever comes.**

a) Your son has not been visiting lately?
b) You're fairly lonely right now, aren't you?
c) He probably wants to come more often but is just too busy.

30. **This is my wife's third operation! How much can she take! When do they say that's enough?**

a) This is her third operation. You're wondering when they are going to stop.
b) Perhaps this operation will make a difference.
c) It's painful for you to watch you wife suffer.

31. **I just want to die. Why can't they leave me alone?**

a) You feel ready. You wonder why others are so reluctant to let it happen.
b) Everyone's just trying to help. Things really could be a lot worse.
c) You just want it to be over and everybody to go away.

32. **I don't like it here. I want to leave. Will you take me home?**

a) You'd like to leave?
b) You have strong feelings about being here.
c) I'd really like to but I'm afraid I can't, besides the nurses are nice here.

33. **It's my life. If I decide I want out that's my right. And certainly with this medication that will be easy enough.**

a) You need to feel in charge of your own life.
b) You have been thinking about ending your life with all this medication.
c) You know no one wants you to hurt yourself and the medication is there only to ease your pain..

34. **I don't want to see any more doctors, take any more chemo or have any more tests! But John (my husband) just keeps insisting.**

a) Maybe John is just trying to help. He is your husband.
b) It's hard to tell your husband how you really feel and what you really want.
c) John keeps on insisting you follow your doctor's orders even though you don't want to.

35. **They don't say how I'm doing. Nobody tells me how I'm really doing.**

a) I'll bet if you asked them they would.
b) You don't know how your health is.
c) You're concerned they might not be being straight with you.

36. **My little girl cries as soon as Bob brings her into my room. She looks to him to do everything for her now.**

a) It's hard to see her turn to her dad for everything.
b) It's probably his way of comforting her.
c) Bob does everything for her right now.

37. **Why do I always get this soft food? I'm not a baby you know.**

a) It's probably easier to digest.
b) You feel like a baby when they serve you strained foods.
c) It's hard to accept limits in so many areas of your life.

38. **Sometimes things around me seem really strange. Yesterday I thought the pictures were moving and my bed seemed to be floating. Is my brain quitting?**

a) It's upsetting to have strange experiences.
b) No, no. You were probably over-tired. Sometimes my eyes get blurry too.
c) Yesterday you had some strange experiences which made it seem like your brain had quit.

39. **I suppose I should make up a will before I die. It seems so final.**

a) Completing a will seems like the end.
b) If you make up a will you feel like you will die soon.
c) Wills are a wise move for anyone.

40. **I've thought about leaving the hospital and never coming back. Just disappearing. No one would notice and it might be a lot faster.**

a) You've thought about just packing it all in and leaving.
b) Sometimes you'd like to take more control of your own life, including your time for death.
c) You wouldn't do that because so many people would be upset and then you would feel guilty.

41. **I don't have anything left. I've sold everything; my clothes, my furniture, my bed. Even my relatives are gone.**

a) Everything is gone....there's nothing left.
b) You feel ready now.
c) The staff and I will always visit you.

42. **It seems like everyday the pain gets a little worse. I ask for more medication. They give it. What's going to happen when the medication won't work any more?**

a) The thought of the pain getting worse is frightening for you.
b) You're wondering if the medication will stop working at some point.
c) Think positively, it's always helped so far.

43. **Death seems so final. I've spent all of my life being so alive. It seems ironic to now die being so lifeless.**

a) Yes, but remember the joy you have brought to others. That's the person they will remember.
b) As you think about your own death, it's hard to imagine just fading away. It's not like you.
c) Cancer makes you feel so lifeless as time passes.

44. **I wonder what would happen if <u>I</u> told the nurses when to sponge bath me, if <u>I</u> told the doctors when to visit me, if <u>I</u> told the priest when to pray for me?**

a) You sound like you need to have some control in your life.
b) Staff have busy schedules to keep and try their best to please.
c) You'd like to tell the nurses, doctors and priests what to do.

45. **I want to watch from my bedroom window the children walk to school in the morning. I want to cook toast in my toaster and eat with my knife and fork. When I die, let it be at home.**

a) The hospital isn't the same as home no matter how hard staff try.
b) Dying at home, where you belong, is very important to you.
c) They will let you bring some of you personal possessions to the hospital, if you want.

46. **I'm not a Christian. I don't know what will happen to my soul after I die. I don't know how to become one now.**

a) You're wondering what will happen to you after your death.
b) I wouldn't worry about that for now. Take care of your health and He will take care of you.
c) You're not sure of how to become a Christian.

47. **I want to get through Christmas. I don't care what else happens but I don't want to spoil this Christmas.**

a) You'd feel guilty if your death came during the Christmas celebration.
b) Your family would understand.
c) You don't want anything to happen at Christmas.

48. **I want to be able to decide what happens to me all the way along. I want to make choices and not have them made for me.**

a) You must keep in mind that hospital staff are there for your benefit.
b) You want to make decisions for yourself.
c) It's your life and you want to run it!

49. **I'm not ready for this. If I had any idea this was coming, I would have done so many things differently.**

a) You weren't ready for this. You have more to do.
b) You feel cheated by your illness. It has raised questions about how you have lived your life.
c) One of the problems we all face is the unpredictability of life.

50. **Why do they look so guilty when they come to visit? I'm the one letting them down.**

a) You're doing the best you can, considering the circumstances. Being hard on yourself won't help.
b) You feel like you're letting them down.
c) You see yourself as failing, not them.

51. **Death seems so unfair. I don't smoke, I don't drink. I know lots of people who do both and they'll probably live to see 100!**

a) Others should be sicker than you, right?
b) You're saying to yourself, "Why me, I don't deserve this. Others have taken worse care of themselves."
c) Life isn't fair but you've had a good life, haven't you?

52. **If I go home for a visit, I feel like I spoil everyone else's weekend so I can enjoy mine. I suppose I shouldn't go.**

a) Staying at the hospital won't bother anyone else.
b) You really want to be at home without being a bother.
c) Nonsense! I'm sure they will be glad to have you.

APPENDIX C

Items Eliminated By Expert Validation

1. **The physiotherapist is always wanting me to walk but I'm so tired. The dietitian is always wanting me to eat.**

   a) You need food and exercise to keep up your strength. They are probably just trying to help.
   b) You're tired of people expecting so much of you.
   c) The physiotherapist and dietitian keep wanting a lot from you.

2. **This home care nurse was here this morning. She talked to me about dying at home. But what about the pain?**

   a) You have fears about the pain if you go home.
   b) You talked about going home to die?
   c) Maybe it would be more comforting to you to stay in the hospital.

3. **I can sleep in the daytime but I just can't sleep at night. If I drift off, I wake up with a start and my heart is pounding.**

   a) Sleeping at night is harder than during the day when people are around.
   b) Perhaps you should speak to your doctor about this. He may be able to help.
   c) You're worried about sleeping at night in case you don't wake up, aren't you?

4. **I keep getting these new pains. I think maybe it will mean another operation. I hate surgery.**

   a) But what if the surgery would stop the pain? Surely then it's worth it.
   b) Surgery and operations are not what you want right now.
   c) You really hope you won't have to have any more surgery.

5. **I go to church every Sunday. I read the Bible. "Keep the faith" they say, believe in miracles..., but what hope is there really?**

   a) You should speak with our minister who visits regularly. I'm sure he could help.
   b) How can you believe in God when there isn't any hope?
   c) Your faith in God is in doubt because you are terminally ill and it doesn't seem fair.

6. **It's sad. I'm just now appreciating the importance of my friendships that I've had and will soon lose.**

   a) Try thinking about the good times that you have had with your friends.
   b) You're thinking about what your are going to lose soon.
   c) You're feeling sad about the friendships you've had and not appreciated until now.